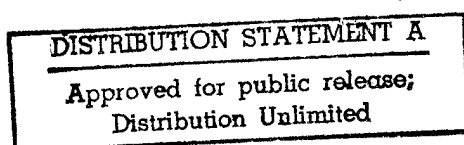
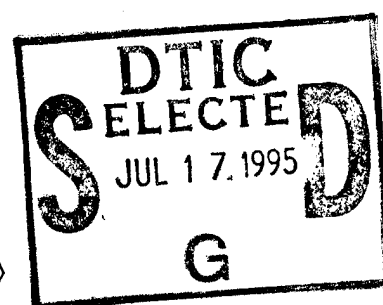
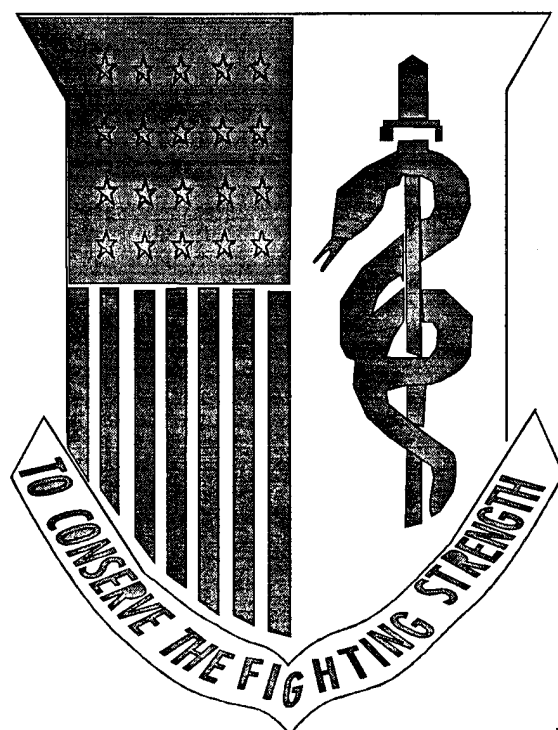


UNITED STATES ARMY MEDICAL DEPARTMENT

REORGANIZATION



19950714 087

VOLUME II ENCLOSURES 1-10

DTIC QUALITY INSPECTED 5



TASK FORCE AESCULAPIUS
JANUARY 1993 - JUNE 1995



36K

REPORT DOCUMENTATION PAGE

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1. AGENCY USE ONLY (Leave blank)		2. REPORT DATE * 16 June 1995		3. REPORT TYPE AND DATES COVERED Final Jan 93 - Jun 95	
4. TITLE AND SUBTITLE United States Army Medical Department *Reorganization Volume II - Enclosures 1-10				5. FUNDING NUMBERS	
6. AUTHOR(S) COL John Miller, Dr. Steve Clement, LTC Clyde Hoskins, MAJ Howard Schloss					
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) *Office of the Surgeon General, U.S. Army HQDA (DASG-TT) 5109 Leesburg Pike Falls Church, VA 22041-3258				8. PERFORMING ORGANIZATION REPORT NUMBER	
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES) Office of the Surgeon General, U.S. Army HQDA (DASG-ZA) 5109 Leesburg Pike Falls Church, VA 22041-3258				10. SPONSORING/MONITORING AGENCY REPORT NUMBER	
11. SUPPLEMENTARY NOTES					
12a. DISTRIBUTION/AVAILABILITY STATEMENT *Distribution Statement A: Approved for public use; distribution is unlimited.				12b. DISTRIBUTION CODE	
13. ABSTRACT (Maximum 200 words) This report provides a synopsis of the work surrounding the Army Medical Department (AMEDD) reorganization during the period January 1993 to June 1995. Volume I of the report documents the formation of Task Force Aesculapius; the role of Organizational Design, Incorporated; and the impact of the reorganization on other AMEDD activities. Other topics covered include background reasons for the reorganization, the analytical process, concept plan development, implementation of the concept plan, major subordinate command analyses, marketing the reorganization, and related issues. Volumes II, III, IV, and V contain enclosures which include the MEDCOM Concept Plan, Task Force charters, selected reorganization briefings, and major subordinate command reviews. DTIC QUALITY INSPECTED B					
14. SUBJECT TERMS AMEDD Reorganization, Task Force Aesculapius, MEDCOM, AMEDD, TFA, OTSG, TSG				15. NUMBER OF PAGES	
				16. PRICE CODE	
17. SECURITY CLASSIFICATION OF REPORT Unclassified	18. SECURITY CLASSIFICATION OF THIS PAGE Unclassified	19. SECURITY CLASSIFICATION OF ABSTRACT Unclassified	20. LIMITATION OF ABSTRACT		

ENCLOSURE 1



REPLY TO
ATTENTION OF

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
5109 LEESBURG PIKE
FALLS CHURCH, VA 22041-3258



DASG-TT

5 FEB 1993

MEMORANDUM FOR AMEDD Stakeholders

SUBJECT: Charter for Project AMEDD Vanguard (Task Force Aesculapius)

I. APPOINTMENT: The following personnel are appointed to Project AMEDD Vanguard (Task Force Aesculapius): MG Girard Seitter, III, MC; COL Stephen Xenakis, MC; COL Mary Messerschmidt, AN; COL John Miller, DC; LTC Clyde Hoskins, VC; LTC John Zurcher, MS; MAJ Mary Carstensen, SP; MAJ James Rosengren, MS; MSG Sandra Pogue

II. MISSION: Recommend to TSG alignment of the mission, functions and structure of the AMEDD to support its Strategic Vision (encl) and prepare an implementation plan for the transformation of the AMEDD.

III. AUTHORITY, RESPONSIBILITY AND ACCOUNTABILITY:

A. AUTHORITY: The Surgeon General of the Army

B. RESPONSIBILITY:

1. Review, analyze and synthesize TSG guidance, current literature, past studies, current functional assessments and recommendations, and stakeholder input into the best organization of the AMEDD.

2. Integrate, market and facilitate implementation of the concept of the plan.

C. ACCOUNTABILITY:

1. Objectives:

a. A fully integrated, time-phased, coherent plan for alignment and organization of the AMEDD for approval by The Surgeon General.

b. Active stakeholder participation in the design and implementation of the requisite organization.

c. A resulting organization which is necessary, appropriate, efficient, effective and provides for incremental improvement.

2. Means: Present concepts and critical elements of the plan to TSG, the Senior Executive Council and advisory groups.

IV. ADMINISTRATIVE SUPPORT: OTSG Staff

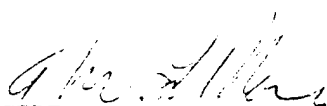
V. SUPERVISORY AND COMMUNICATION CHANNELS:

A. AMEDD Vanguard (TFA) is accountable to TSG, the AMEDD and the Army.

B. Direct communication is authorized with internal/external stakeholders.

VI. TERMINATION AND REVIEW: This Charter will be revised or terminated at my direction.

Encl

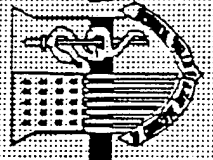

ALCIDE M. LANOUE
LIEUTENANT GENERAL
The Surgeon General

TSG

AMEDD VISION

The Army Medical Department -- A well-managed, quality health care system ready to support our soldiers at home and abroad, accessible to the Army family, accountable to the American people.

LTG Alcide M. LaNoue, TSG



(ENCL)

TASK FORCE AESCULAPIUS

ORIGINAL TEAM MEMBERS

- MG GIRARD SEITTER, III, MC
- COL STEPHEN XENAKIS, MC
- COL MARY MESSERSCHMIDT, AN
- COL JOHN MILLER, DC
- LTC JOHN ZURCHER, MS
- LTC CLYDE HOSKINS, VC
- MAJ MARY CARSTENSEN, SP
- MAJ JAMES ROSENGREN, MS
- MSG SANDRA POGUE, ENLISTED CORPS

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DTIC	TAB <input type="checkbox"/>
Unannounced	<input type="checkbox"/>
Justification	
By _____	
Distribution / _____	
Availability Codes	
Dist	Avail and / or Special
A31	

ENCLOSURE 2

LOG OF INTERVIEWS

27 November 1992 - COL Fogelsong, USAF Cofs Operations Group
3 December 1992 - MG Bussey, DSG
14 December 1992 - Dr. Lanier, DASD(HA)
14 December 1992 - LTG Williams, CDR Corps of Engineers
15 December 1992 - Jane McMullin/Pat DeLeon
16 December 1992 - Dr. Joy, Historian
16 December 1992 - Mr. Roberts, staffer for Congressman Murtha
17 December 1992 - LTC(P) Crissey, Van Straten Study Veteran
January 1993 - General Thurman
4 January 1993 - MG Cameron, CDR, HSC
5 January 1993 - LTG Jaco, CDR 5th Army
7 January 1993 - MG Moore, CDR AMEDD C&S
8 January 1993 - MG(R) Baker, former CDR HSC
8 January 1993 - LTG(R) Ledford, former TSG
19 January 1993 - MG Tempel, DSG
21 January 1993 - MG Travis, CDR WRAMC
22 January 1993 - MG Blanck, CDR WRAMC
25 January 1993 - MG Bonnebeau, DSG (Mobilization & Reserve
Affairs
27 January 1993 - Mr. Pete Esker, TSG PAO
29 January 1993 - COL Coley, Chief OTSG RM
2 February 1993 - BG Adams, Chief Army Nurse Corps
5 February 1993 - COL Claypool, Chief Medical Corps
8 February 1993 - LTG Dominy, DAS

8 February 1993 - COL Johnson, Chief Veterinary Corps
 9 February 1993 - COL(R) Swift, former Chief AMSC
 11 February 1993 - MG Chandler, ASG for NG Affairs
 12 February 1993 - LTC(P) Crissey, AXO, TSG
 12 February 1993 - BG Foust, Chief Medical Service Corps
 22 February 1993 - COL Maxwell, HFPA
 2 March 1993 - COL Jackman, Special Asst to TSG
 2 March 1993 - COL Waters, OTSG XO
 10-13 March 1993 - 7th MEDCOM Principle Staff
 10 March 1993 - DCINC, USAEUR
 11 March 1993 - MG Scotti, CG 7th MEDCOM
 11 March 1993 - BG Brady, DCG 7th MEDCOM
 23-26 March 1993 - COL Timboe & 18th MEDCOM Principle Staff
 24 March 1993 - LTG Crouch, CG EUSA DCINC, Korea
 25 March 1993 - GEN Riscossi, CINC Korea
 30 March 1993 - LTG Fields, DCINCPAC
 30 March 1993 - LTG Corns, CG USARPAC
 31 March 1993 - MG Ord, CG 25th Division
 31 March 1993 - TAMC Principle Staff
 2 April 1993 - COL Donahue, CDR, USAMMA
 10 April 1993 - RADM Martin, Acting ASD(HA)
 13 April 1993 - CSM Robert Adams, TSG CSM
 20 April 1993 - COL Greathouse, Chief Medcial Specialist Corps
 21 May 1993 - Mr. Singley, DASA (R&T)
 25 May 1993 - Mr. Clark, PDASA (M&R)
 25 May 1993 - Mrs. Chescavage, Nat. Military Family Assn.
 28 July 1993 - Ms. Whitworth, U.S. Army Family Liaison Office

ENCLOSURE 2

ENCLOSURE 3

U.S. Army Center for Health Promotion and Preventive Medicine
DLS ANALYTICAL CHEMISTRY LABORATORIES

I. BACKGROUND

The Directorate of Laboratories Sciences (DLS) provides analytical support to a variety of USACHPPM environmental and occupational health programs. In addition, DLS provides similar support for DA, and DOD programs as well as other federal government agencies. This support ranges from sample analysis, method development, consultation to document review and readiness issues.

II. FINDINGS

1. There is a lack of clarity with regard to DLS turnaround time requirements and goals.
2. DLS turnaround time seems excessive.

III. ISSUES

1. What is the current DLS turnaround status?
2. How should the Theater Army Medical Laboratory (TAML) be best integrated into USACHPPM?

IV. DISCUSSION

During interviews conducted at USACHPPM, the turnaround time of DLS laboratories was mentioned several times. In addition, there seems to be a lack of clarity, in some cases, as to the

turnaround time requirements for the samples received.

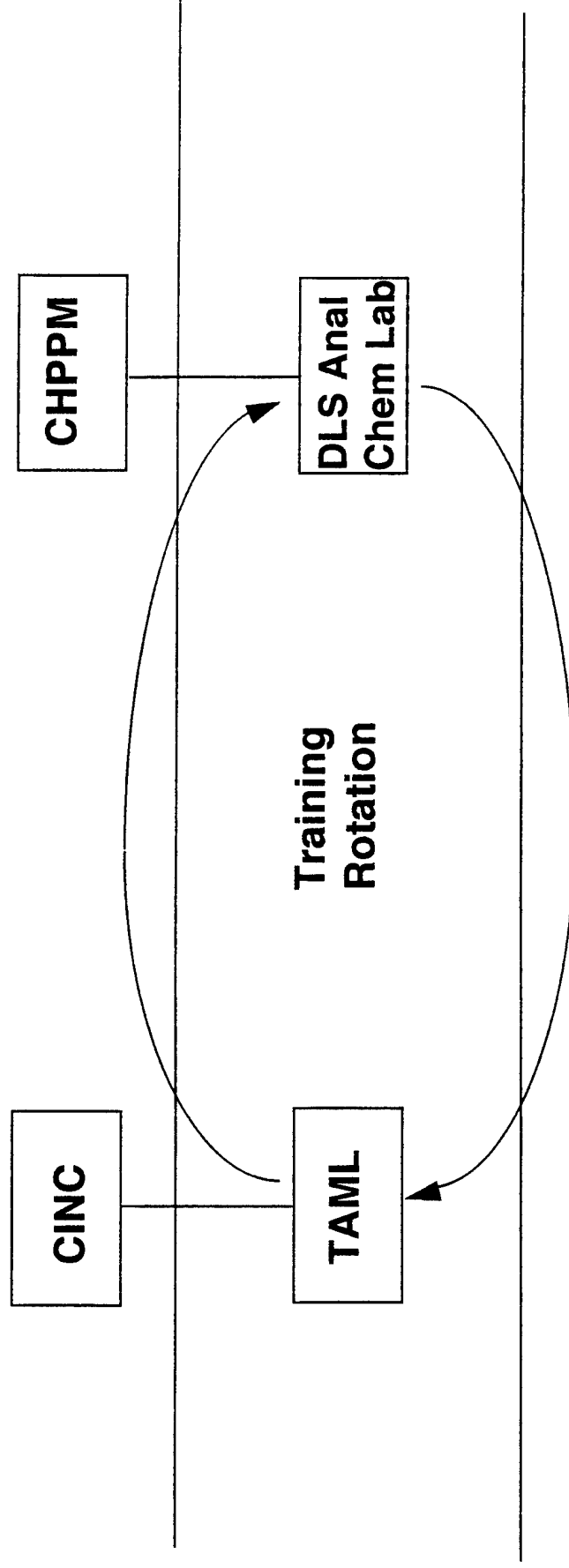
Management also needs to decide the primary focus of DLS. Should they be a production laboratory, method development laboratory or a combination of both?

A unique challenge facing USACHPPM is how best to meet the training requirements of personnel assigned to the TAML. The TAML training mission is scheduled for transfer to USACHPPM. Initial discussions involved rotating people through the CHPPM laboratories in Edgewood for training in the various analytical procedures that constitute the required knowledge base when the TAML is fully operational.

V. RECOMMENDATIONS

1. Management must decide the primary focus of the DLS laboratories.
2. DLS personnel should rotate through the TAML doing some of the work that will be transferred back to the main labs from the DSA's. This will provide realistic training in tasks expected to be performed in field laboratory settings.

THEATER ARMY MEDICAL LABORATORY



ENCLOSURE 4

EXECUTIVE LEADERSHIP PRINCIPLES

BY

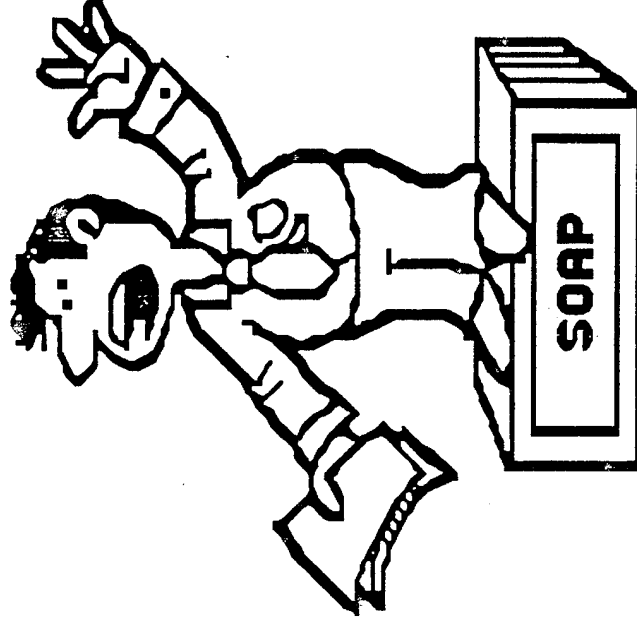
**STEPHEN D. CLEMENT, Ph.D.
ORGANIZATIONAL DESIGN INC.
BOERNE, TEXAS**

ORGANIZATIONAL DESIGN PRINCIPLES

- **ORGANIZE AROUND THE WORK**
 - **STRATEGIC**
 - **OPERATIONAL**
 - **TACTICAL**
- **ESTABLISH CLEAR ACCOUNTABILITIES
& AUTHORITIES**
- **CONCENTRATE ON THE CORE BUSINESS**
- **FOCUS ON THE CUSTOMER**

FUNDAMENTAL DESIGN PRINCIPLES

1. ESTABLISH CLEAR
ACCOUNTABILITY AND
AUTHORITY
2. ORGANIZE AROUND
THE WORK



MANAGERIAL ACCOUNTABILITIES

ESTABLISH CLEAR ACCOUNTABILITY

A **MANAGER** is a person in a role who is held accountable for:

- His/Her own output
- The output of his/her team
- For building and sustaining that team
- For getting the team to follow along with him/her in a common direction while expressing their full individual human capacity in an innovative and creative way

**BUT ACCOUNTABILITY MUST GO
HAND-IN-HAND WITH AUTHORITY**

IF: Accountable for -----

THEN: Authority to -----

DESIGN PRINCIPLE # 9

ACCOUNTABILITY & AUTHORITY

IF : A Manager is a person in a role who is accountable for:

- achieving his own personal effectiveness
- the output which he assigns to subordinates, and
- for building and sustaining an effective team of subordinates

THEN : He must have the following minimum authorities :

V Veto appointment to his unit (team)

A Assign tasks

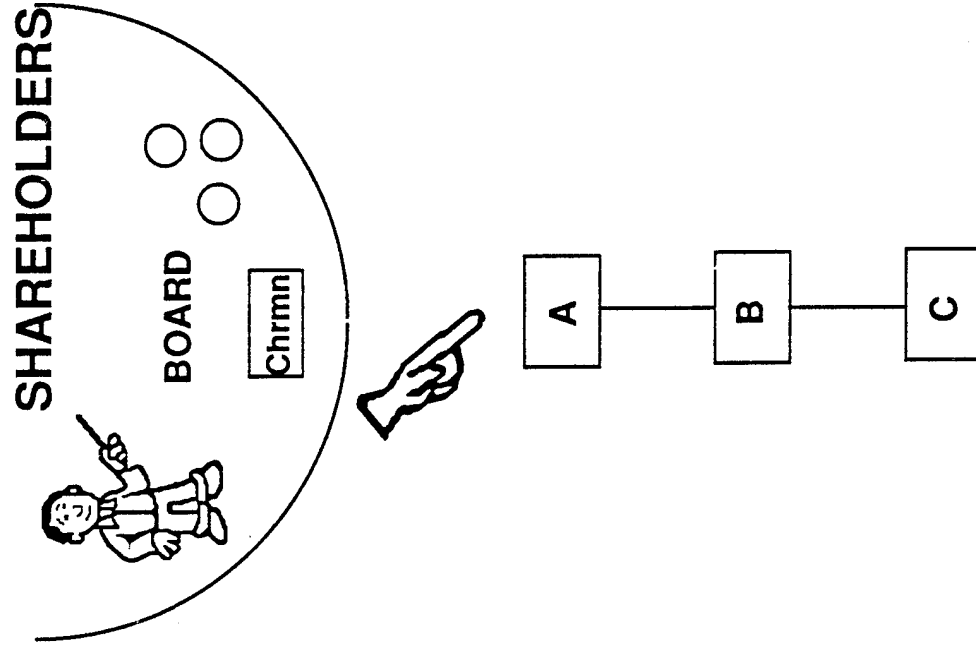
R Assess personal effectiveness and reward differentially

I Initiate removal from team

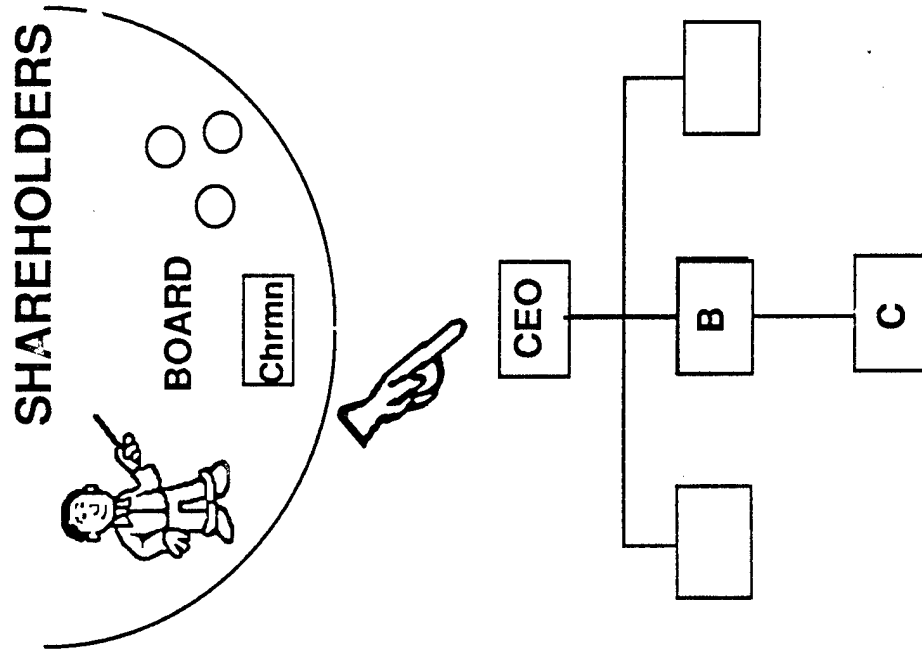
MANAGERIAL ACCOUNTABILITIES AND AUTHORITIES

ACCOUNTABILITY	ORGANIZATIONAL REQUIREMENTS	AUTHORITY
• Output Performance of Others	<ul style="list-style-type: none"> - Time targetted task setting, Task reporting - Reviewing performance of tasks and coaching - Training of team members to upgrade skills 	Assign Tasks
• Building and Sustaining an Effective Team	<ul style="list-style-type: none"> - Selection criteria with MOR - Induction methods - Cumulative judgements of personal effectiveness translated to reward and penalty system including remuneration or removal from role - Implement development program decided by MOR 	<p>Veto Selection to Team</p> <p>Reward Differentially on Personal Effectiveness</p> <p>Initiate Removal from Team</p>

ACCOUNTABILITY HIERARCHY

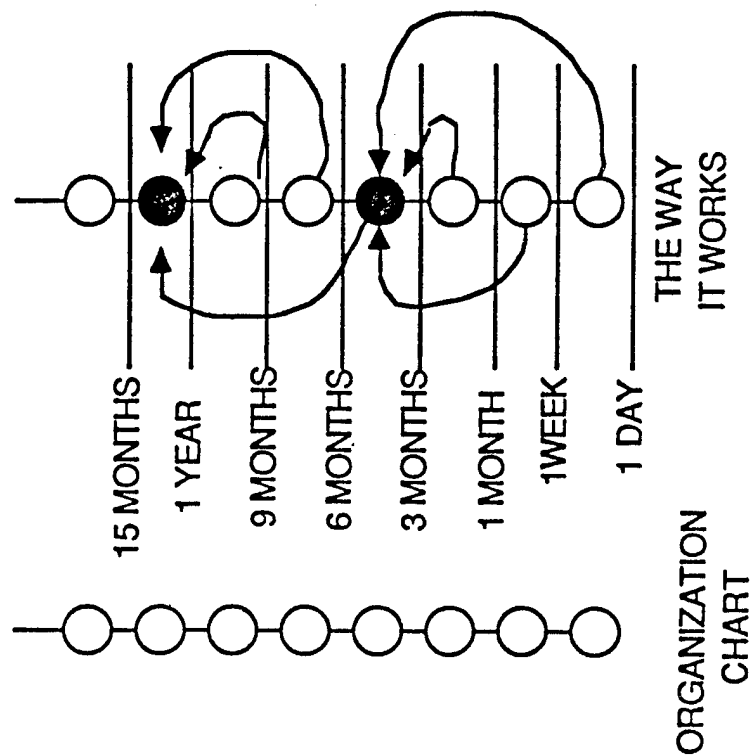


ACCOUNTABILITY HIERARCHY



DESIGN PRINCIPLE # 4

ESTABLISH THE CORRECT NUMBER OF ORGANIZATIONAL LEVELS - 7



VII	CEO'S	50 YEARS
VI	EXEC / GROUP VP'S	20 YEARS
V	BUS. UNIT PRES	10 YEARS
IV	GEN MGRS	5 YEARS
III	UNIT MGRS	2 YEARS
II	FIRST LINE MGRS	1 YEAR
I	OPERATORS	3 MONTHS
		1 DAY

THE WAY IT
OUGHT TO BE

TYPICAL ORGANIZATIONAL PROBLEMS

- TAKES TOO LONG TO GET ROUTINE CHANGES
- WORK IS BEING REVIEWED UNNECESSARILY
- KEY ISSUES ARE OFTEN DELEGATED TO TOO LOW A LEVEL
 - LOTS OF SECOND GUESSING OF THE BOSS
 - "WORD SMITHING"
- TOO MANY LAYERS, DEPUTIES, ASSISTANTS etc.
- NOT EVERY LEVEL "ADDS VALUE"
- SOME PROGRAMS/ACTIVITIES HAVE LOST SIGHT OF THEIR PURPOSE
- DUPLICATION OF EFFORT
- BUREAUCRATIC POLICES/PROCEDURES "CONSUMING" ALL CREATIVE ENERGY

TYPICAL SOLUTIONS

A HOST OF GIMMICKS AND PANACEAS

- SLOGANS AND EXHORTATIONS FOR CREATIVITY AND INNOVATION
- NEW FORMS OF ORGANIZATIONS FOR THE "INFORMATION AGE"
- THE PERENNIAL RETURN OF MBO, THE MATRIX
- MANAGEMENT BY "WALKING AROUND"
- "SITTING ON A LOG"
- TO BE LIKE THE JAPANESE
- TO BE EXCELLENT; AND ALL IN A MINUTE

MY THESIS IS:

- IT IS NOT SOME NEW FORM OF ORGANIZATION THAT IS NEEDED
- NOR IS THE CURRENT ORGANIZATION BROKEN

WHAT IS NEEDED IS:

- TO LEARN AND UNDERSTAND THE EXISTING ORGANIZATION
- TO KNOW HOW TO ORGANIZE AND USE IT PROPERLY

TO DO SO, WE NEED

- **A THEORY**
- **SOME CONCEPTS**
- **AND BASIC PRINCIPLES**

WHAT'S AT STAKE HERE!

**GAINS OF 30% - 50% IN
PRODUCTIVE
EFFECTIVENESS OR CUTS OF
THAT ORDER**

OVERVIEW OF THIS "MAGIC"

- LINK MISSIONS AND FUNCTIONAL AREAS TO ORGANIZATIONAL STRUCTURE
- SHOW YOU A 7 LEVEL SYSTEM OF ORGANIZATIONAL STRUCTURE RELATED TO 7 LEVELS OF TASK AND PROJECT COMPLEXITY
- SHOW HOW THESE LEVELS CORRESPOND TO COMMAND AUTHORITY & ACCOUNTABILITIES
- TO POINT OUT THAT PEOPLE ARE ORGANIZED THIS WAY ALSO
 - THE REASON WE HAVE 7 LEVELS IS TO HANDLE TASK COMPLEXITY
 - TO ADD VALUE, A MANAGER MUST BE ONE FULL LEVEL ABOVE THE SUBORDINATE
- LINK MENTAL COMPLEXITY TO ORGANIZATIONAL LEVEL
- GET AUTHORITY AND ACCOUNTABILITY CONGRUENT

IF YOU APPLY THESE PRINCIPLES PROPERLY

- GET FEWER LEVELS--LESS PASSING OF WORK UP & DOWN
- SPECIFIC FUNCTIONS APPLIED TO A SPECIFIC ORGANIZATIONAL LEVELS--EXPOSES REDUNDANCIES AND EXCESSES
- CLEARER INSTRUCTIONS
- SHARPER ACCOUNTABILITY
- CDR/MGR IN POSITIONS TO "ADD VALUE"
- PEOPLE WITH THE RIGHT CAPACITY WORKING ON ISSUES AT THE RIGHT LEVEL
- "GENERALS DOING GENERALS WORK"
- MORE EFFECTIVE ASSESSMENT OF PERSONAL EFFECTIVENESS AND INDIVIDUAL POTENTIAL

BASIC CONCEPTS

FOCUS:



- ACCOMPLISHING MISSIONS AND GOALS
- CARRYING OUT "TASKS", PROJECTS
PROGRAMS

BASIC CONCEPTS

AIM: ORGANIZE TO ACCOMPLISH MISSIONS AND GOALS

- A "GOAL" IS A WHAT BY WHEN

OUT COME: GETTING THINGS DONE ON TIME

GOAL & TASK COMPLEXITY

GOALS & TASKS COME IN DEGREES OF COMPLEXITY

- THE COMPLEXITY LIES IN WHAT YOU HAVE TO DO TO COMPLETE THE TASK; ie. THE PROBLEMS YOU HAVE TO OVERCOME
- AS YOU GO HIGHER IN THE ORGANIZATION, TASKS BECOME MORE AND MORE COMPLEX

TASK COMPLEXITY

TASK COMPLEXITY COMES IN QUANTUM JUMPS

CORPS

- DIAGNOSTIC ACCUMULATION OF INTERNATIONAL DATA • EMPLOY ON-CALL JOINT RESOURCES

DIVISION

- UNIFIED WHOLE SYSTEM
- VISUALIZE THE WHOLE BATTLEFIELD
- IDENTIFY 2D ORDER CONSEQUENCES

BDE

- PARALLEL PROCESSING
- CROSS ATTACHING
- SHIFTING RESOURCES BETWEEN UNITS

BN

- ALTERNATIVE ROUTES TO GOAL
- TASK ORGANIZE

COMPANY

- ACCUMULATES ESSENTIAL INFORMATION
- DETERMINE MAGNITUDE OF CONTACT

PLT/SQD

- PRACTICAL JUDGEMENT
- IMMEDIATE ACTION DRILLS

FIG 6
14

ORGANIZATIONAL
DESIGN INC. 1993

COMPLEXITY AND STRUCTURE

TASK COMPLEXITY ORGANIZATIONAL STRUCTURE

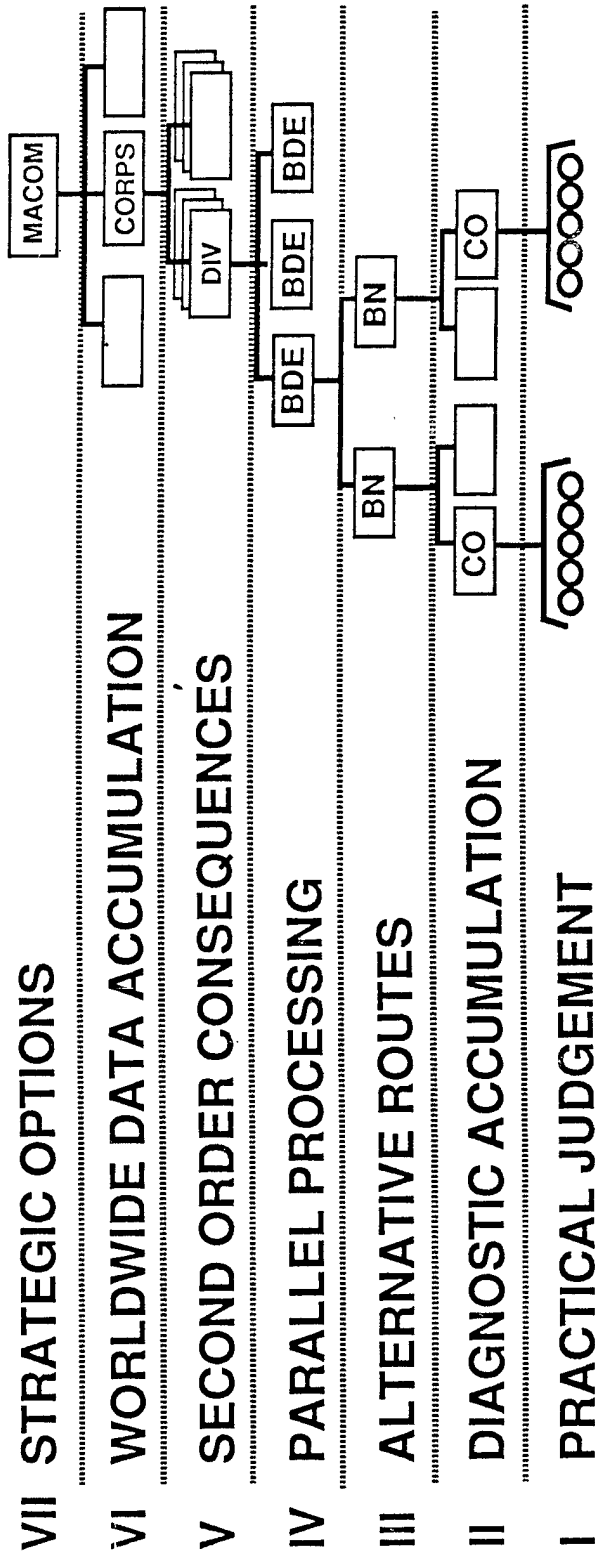


Fig 7
16

WORK, STRUCTURE, AND CAPABILITY

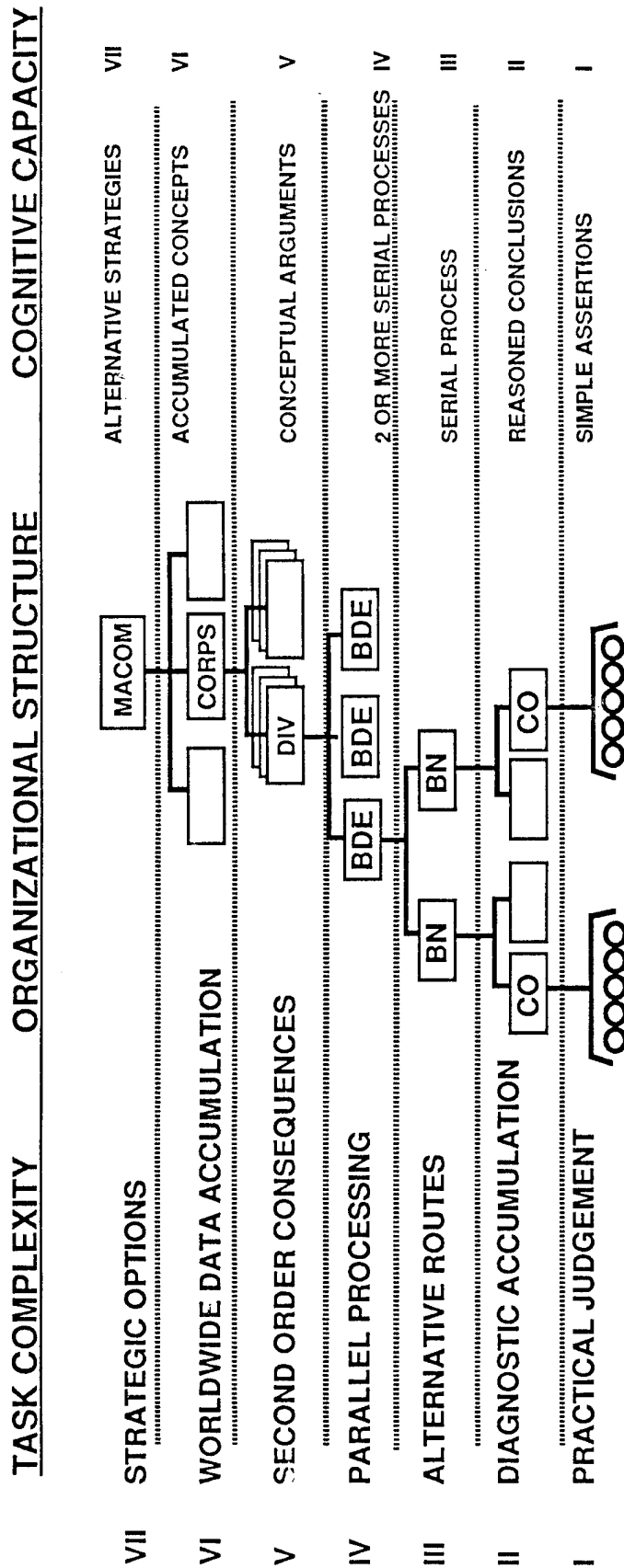


Fig 8
18

DESIGN PRINCIPLE # 6

FOCUS ON GETTING WORK DONE THIS REQUIRES A CLEAR DEFINITION OF WORK

PROBLEM:

That was tough WORK doing the WORK they gave me to do at WORK today

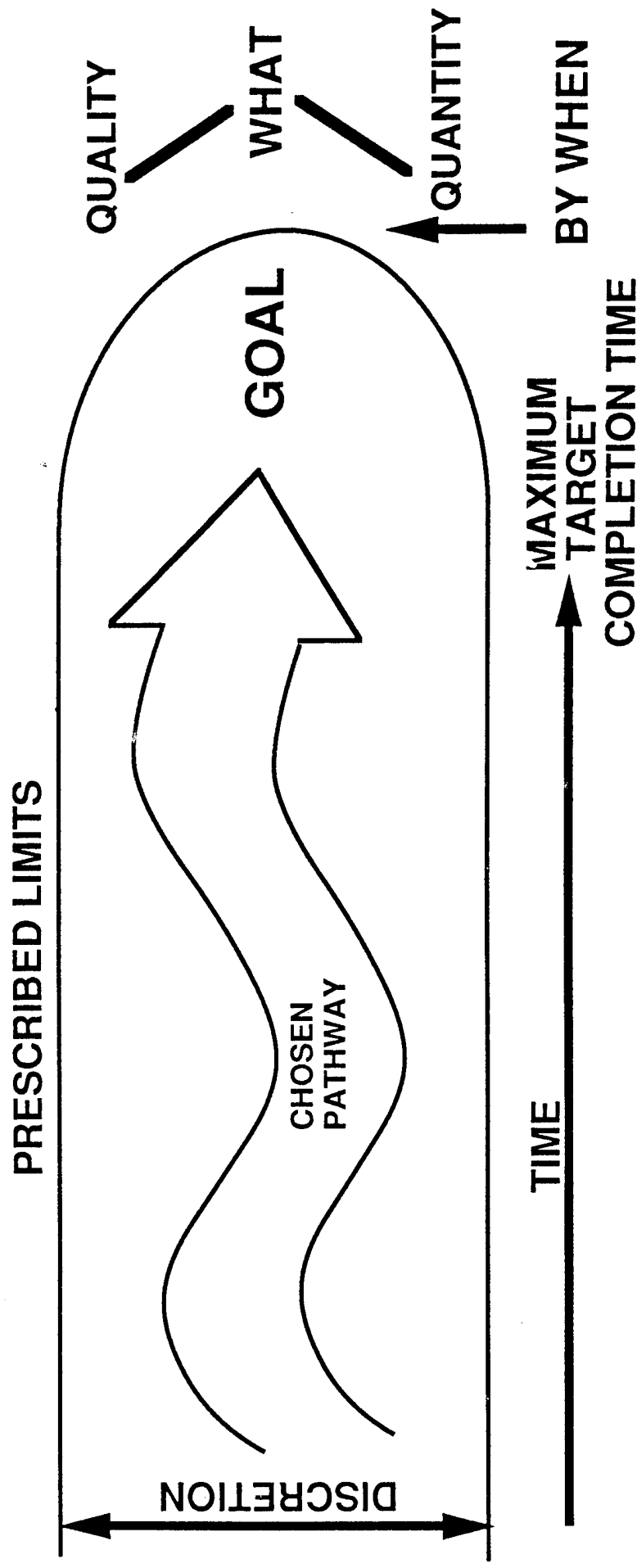
my effort	my tasks or assignments	my place of work
--------------	-------------------------------	------------------------

SOLUTION:

- WORK - THE USE OF DISCRETION AND JUDGEMENT IN MAKING DECISIONS
OR IN CARRYING OUT A TASK
- TASK - AN ASSIGNMENT TO PRODUCE SPECIFIED OUTPUT (INCLUDING
QUANTITY AND QUALITY) WITHIN A TARGETED COMPLETION
TIME, WITH ALLOCATED RESOURCES, AND WITHIN SPECIFIED LIMITS
- ROLE - A POSITION OCCUPIED IN THE ORGANIZATION

WORK IS DEFINED AS :

EXERCISE OF DISCRETION WITHIN LIMITS
TO ACHIEVE AN OBJECTIVE WITHIN
MAXIMUM TARGET COMPLETION TIME



LEVEL I COMPLEXITY

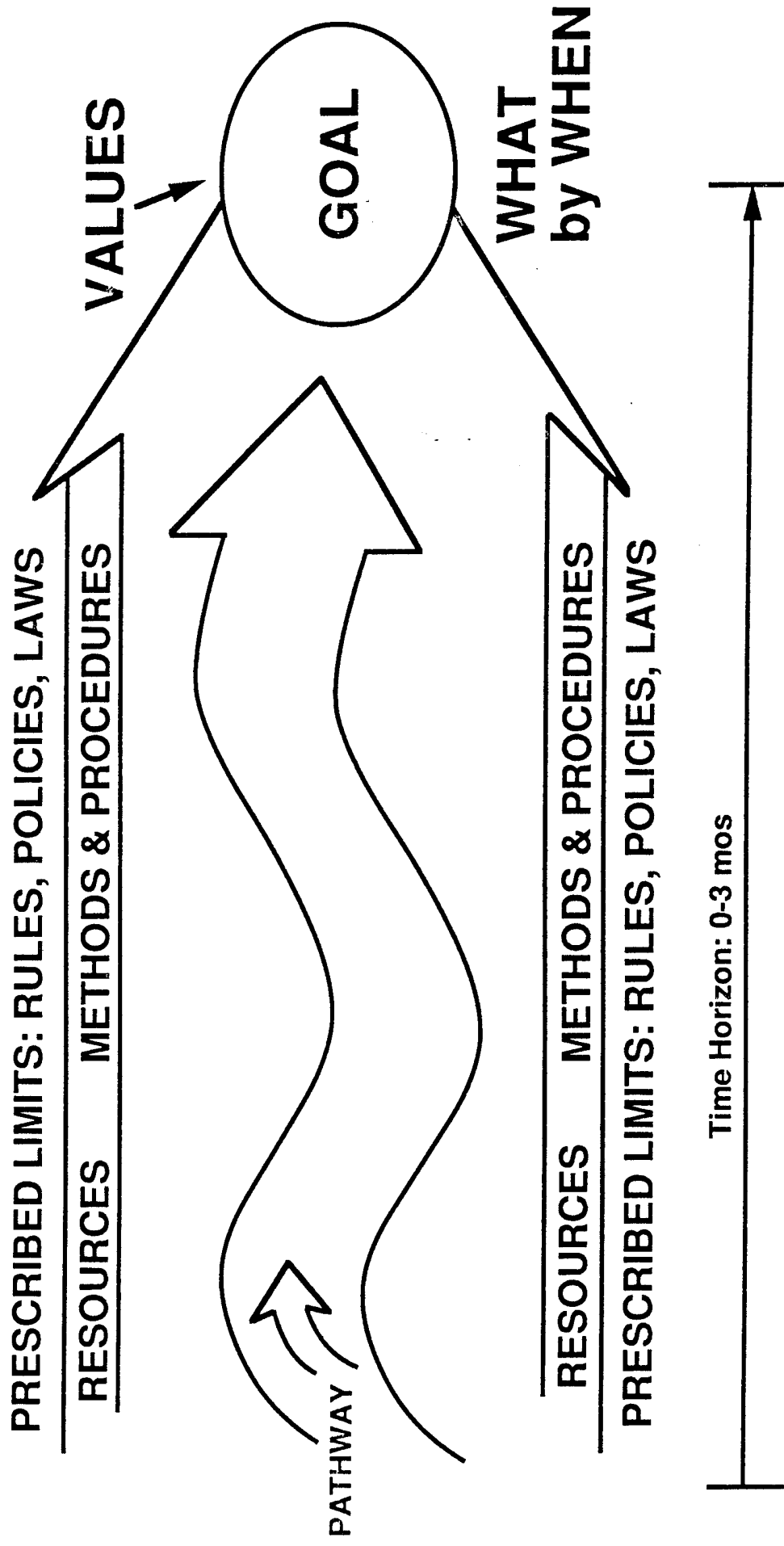


Fig 1

LEVEL II COMPLEXITY

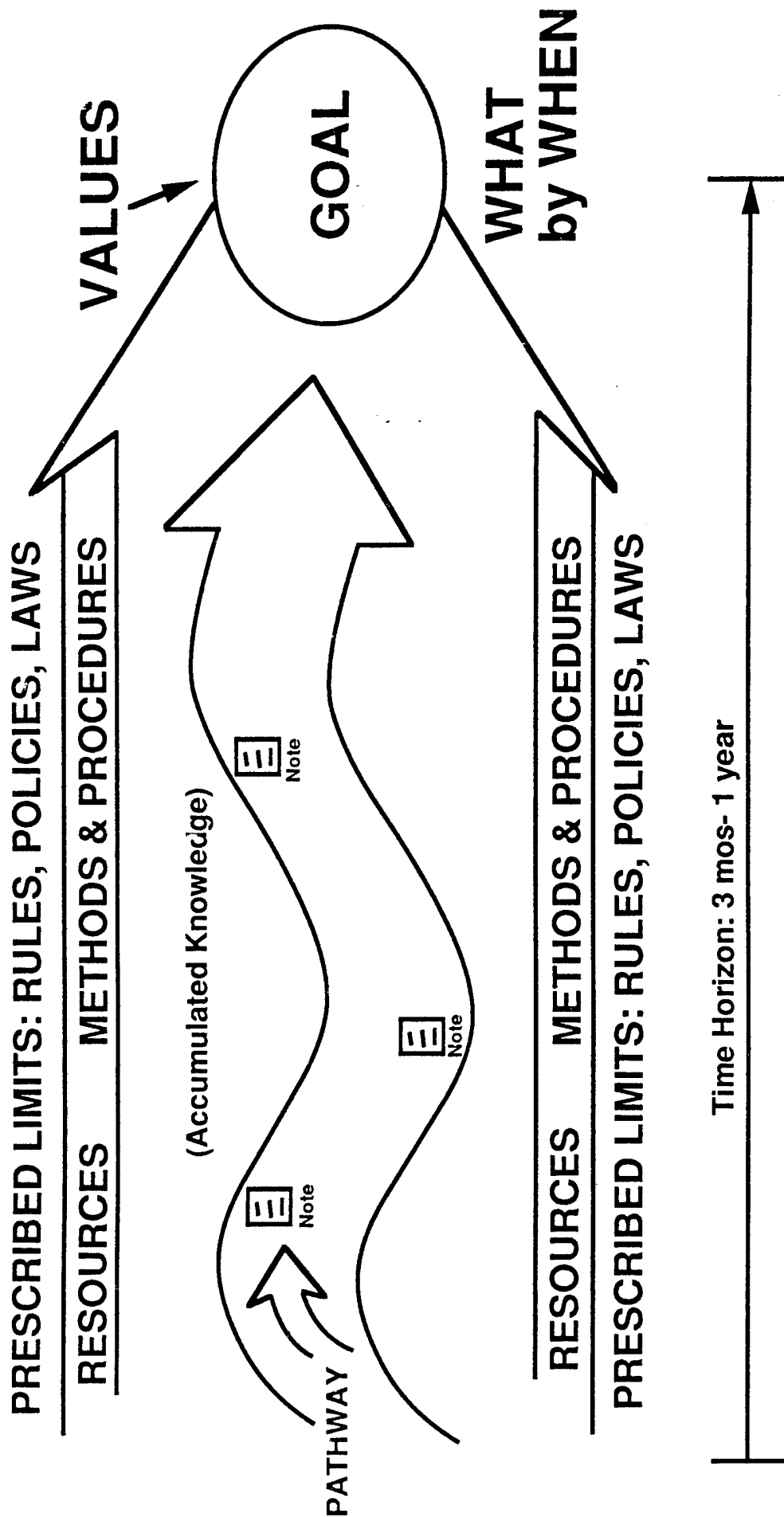
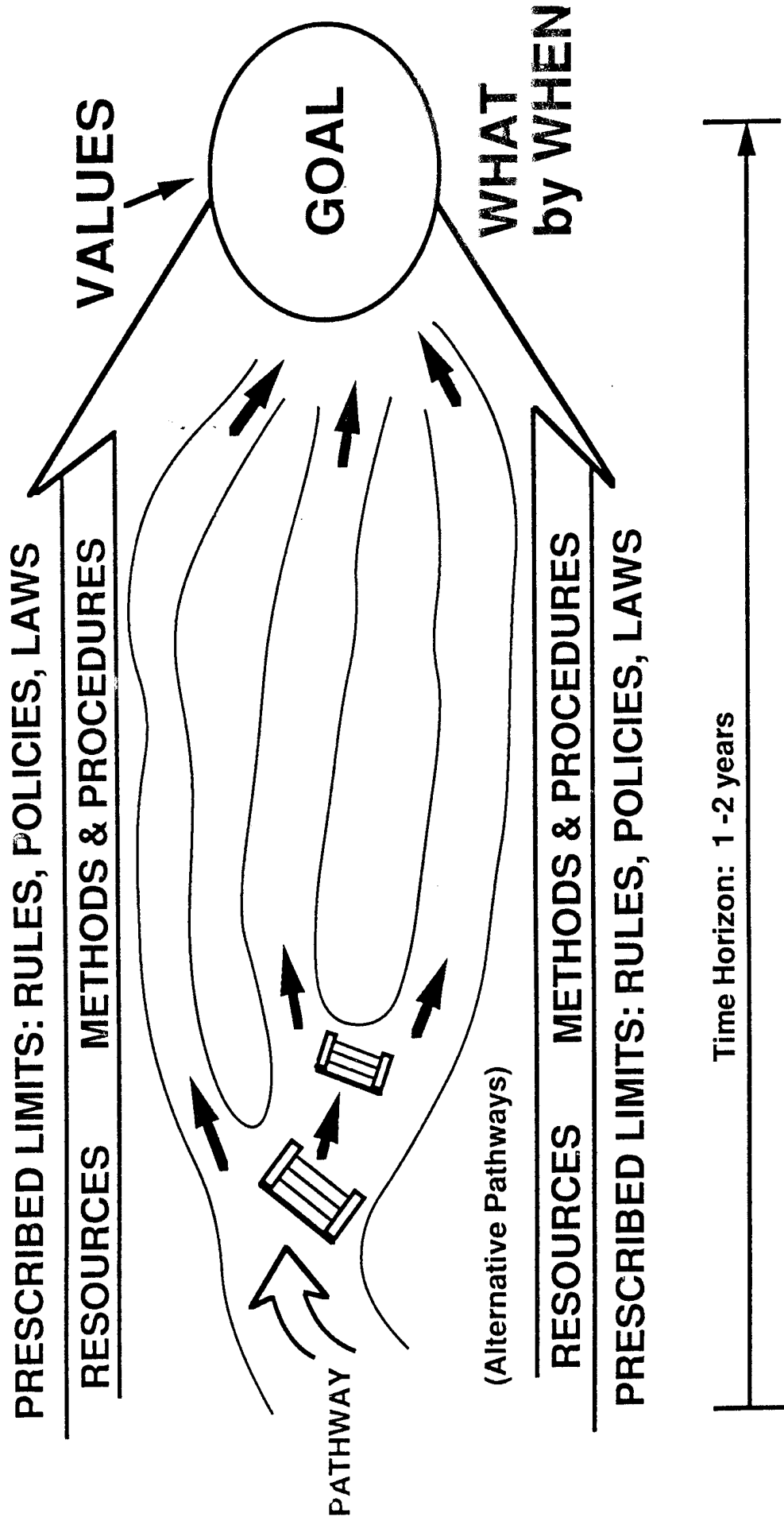


Fig 2

LEVEL III COMPLEXITY



LEVEL 1 COMPLEXITY

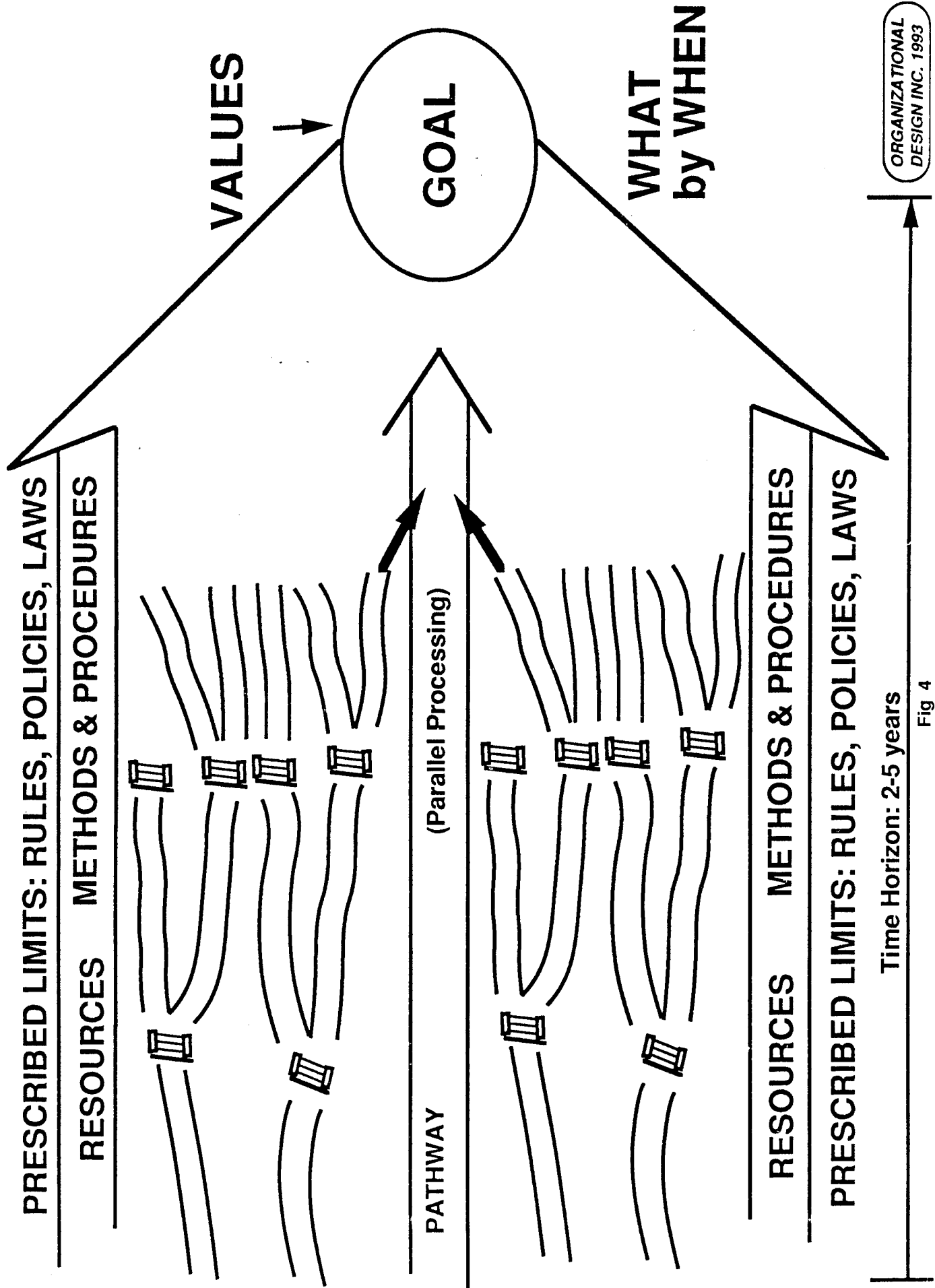


Fig 4

LEVEL V COMPLEXITY

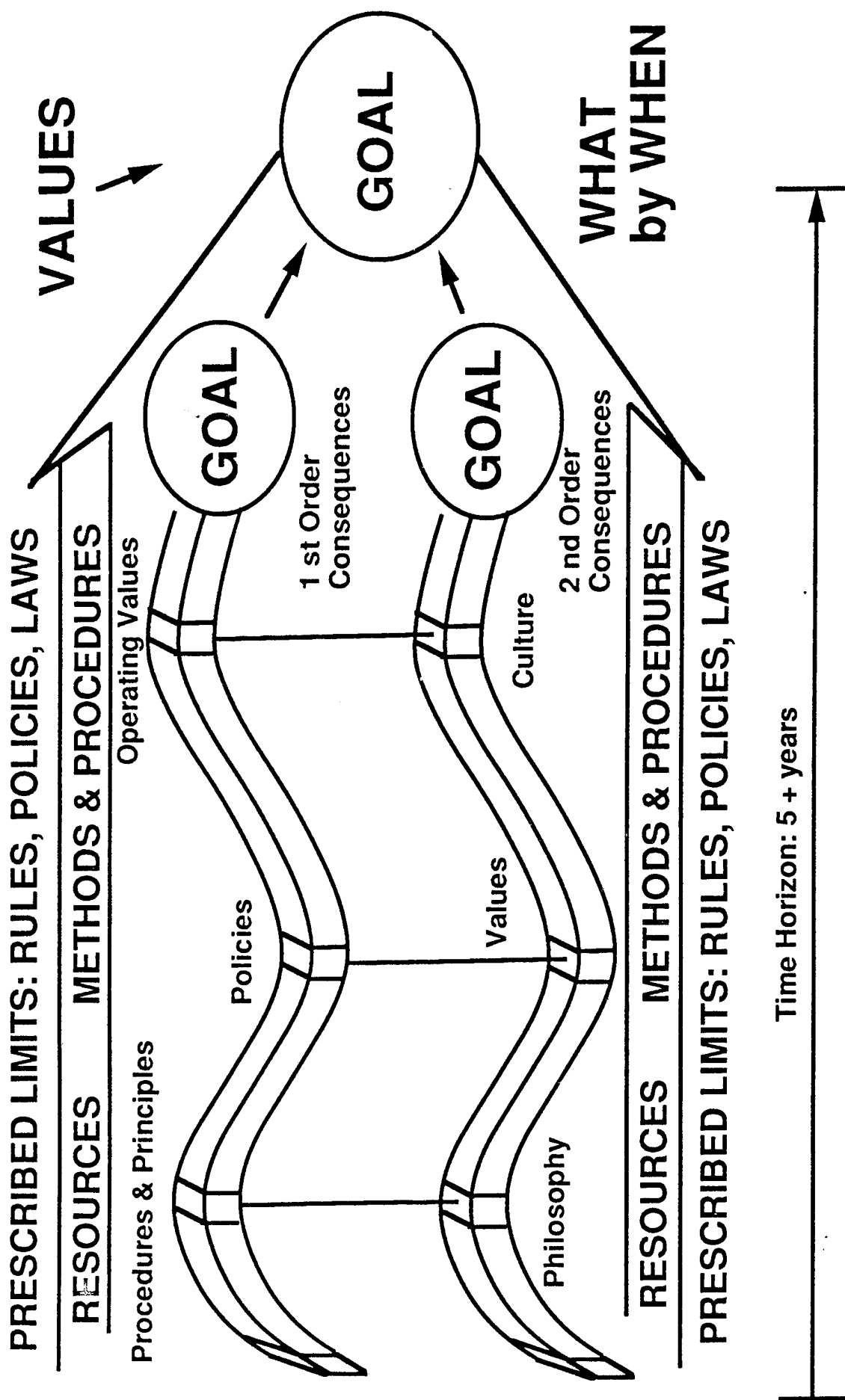


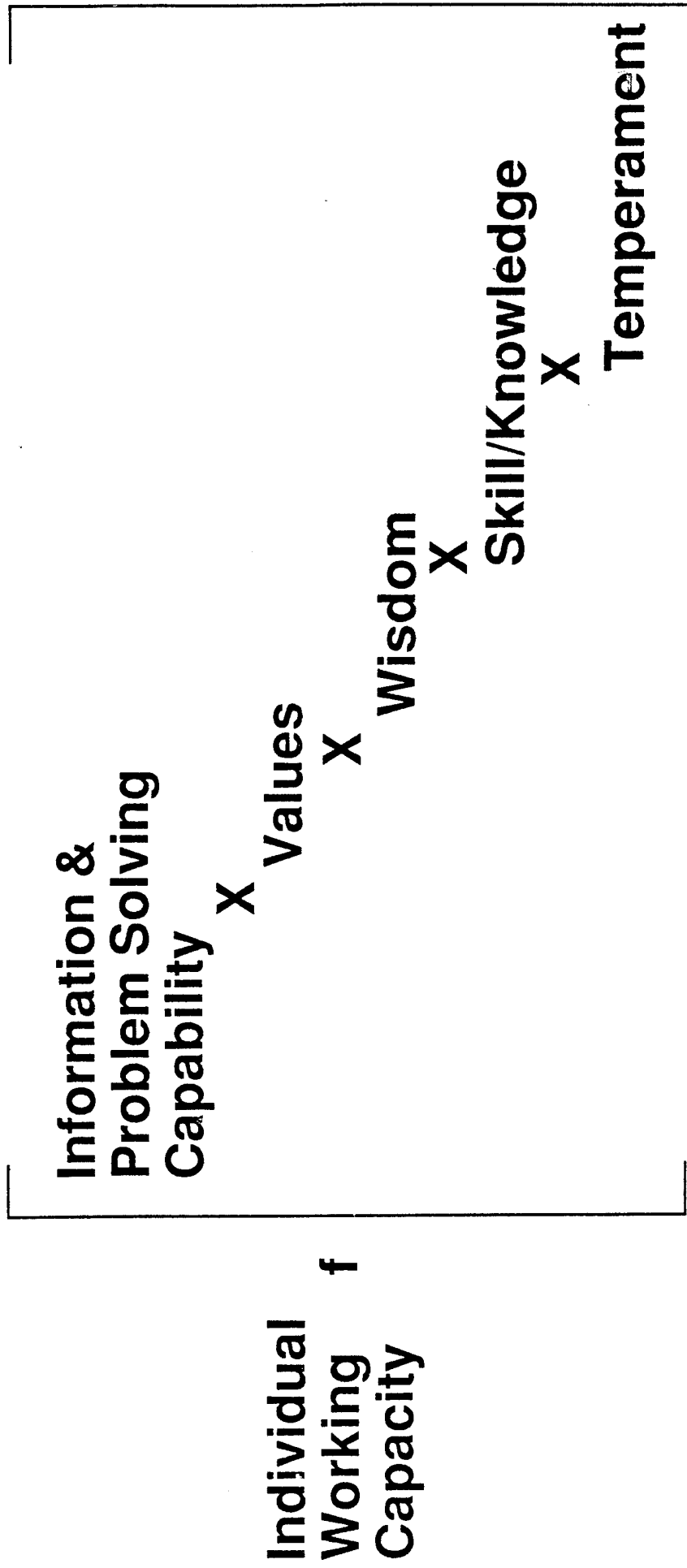
Fig 5

HANDLING COMPLEXITY

is at the heart of

SOLVING PROBLEMS

INDIVIDUAL WORKING CAPACITY



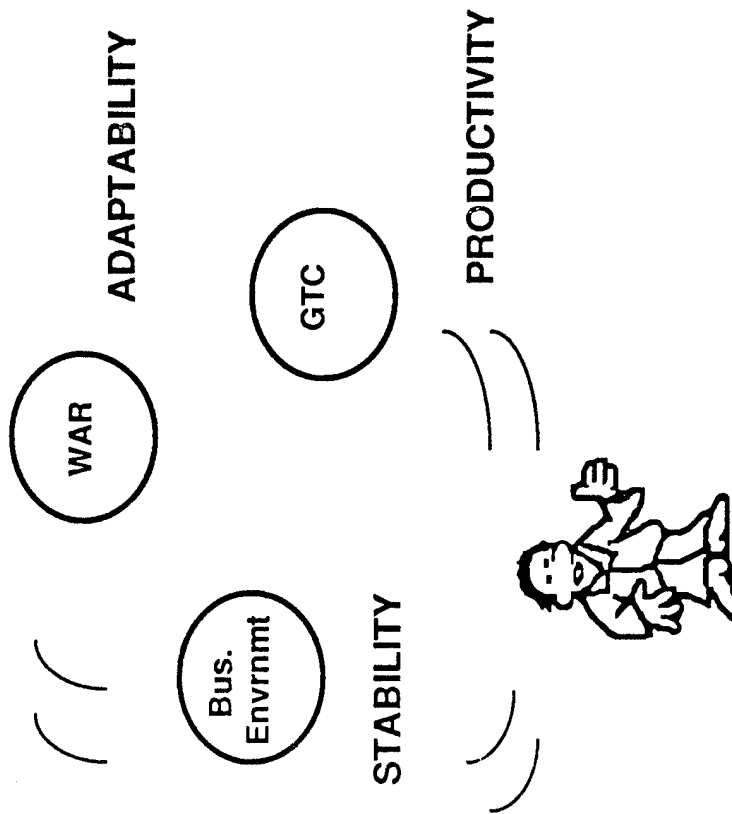
ADDING VALUE

MANAGERS ADD VALUE TO THE WORK OF THEIR SUBORDINATES
BY SETTING AN EFFECTIVE CONTEXT FOR THEIR WORK
TO BE ABLE TO DO SO, MANAGERS MUST BE IN THEIR NEXT
HIGHER DISCRETIONARY MIND SET FROM THEIR SUBORDINATES
IF THEY ARE IN THE SAME DISCRETIONARY LEVEL THEY CANNOT
SET A PROPER CONTEXT FOR ASSIGNING TASKS AT THIS LEVEL
OF WORK

WORK & COMPLEXITY

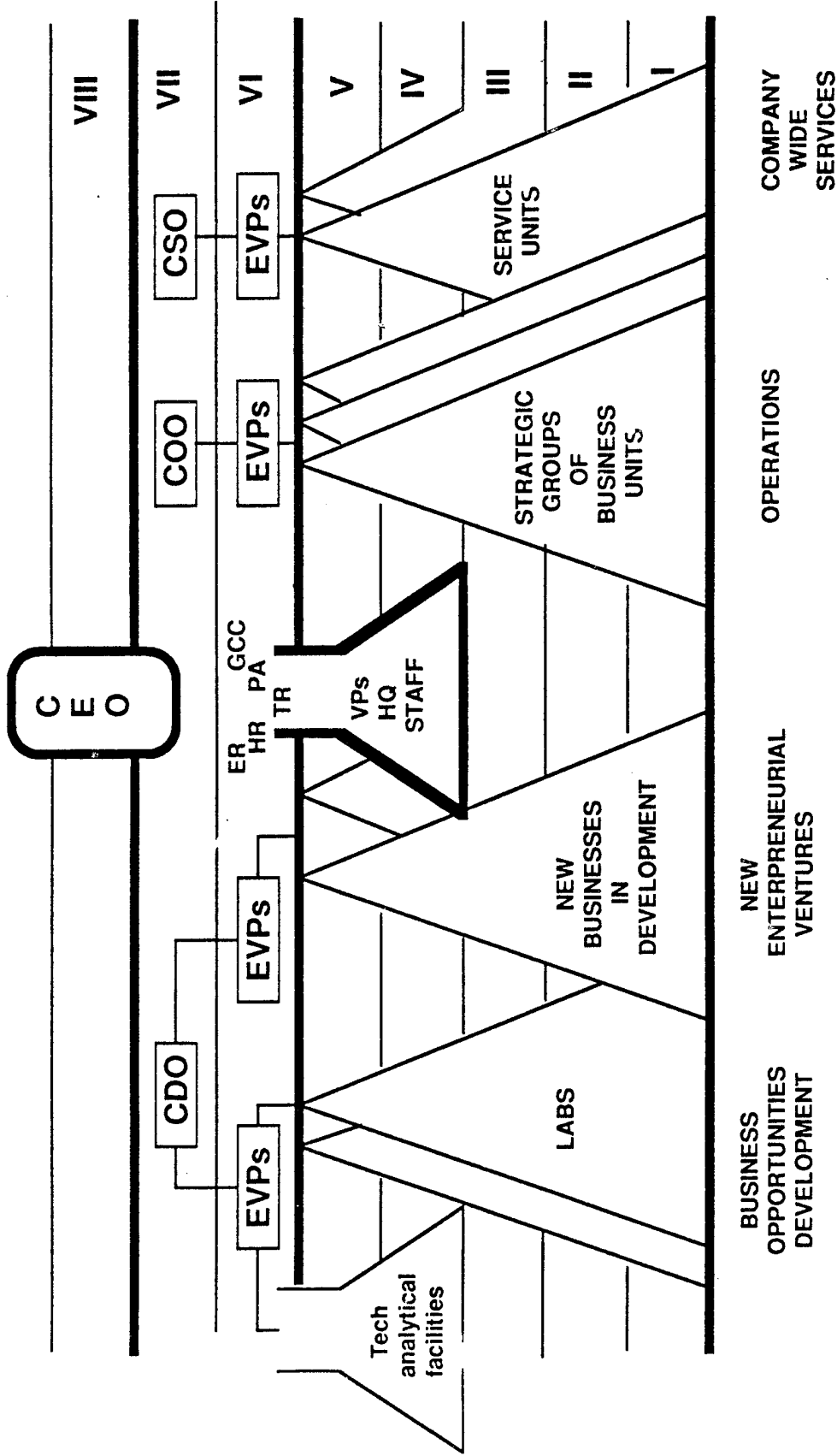
- INDIVIDUALS ARE CAPABLE OF OPERATING AT THEIR CURRENT LEVEL OF WORK
- THEY ARE CAPABLE OF UNDERSTANDING WORK ONE LEVEL UP
- THEY ARE ABLE TO DESCRIBE AND ARTICULATE WORK REQUIREMENTS ONE LEVEL DOWN

**CORPORATE MISSION:
PROFITABLY SATISFYING THE
NEEDS OF CUSTOMERS**

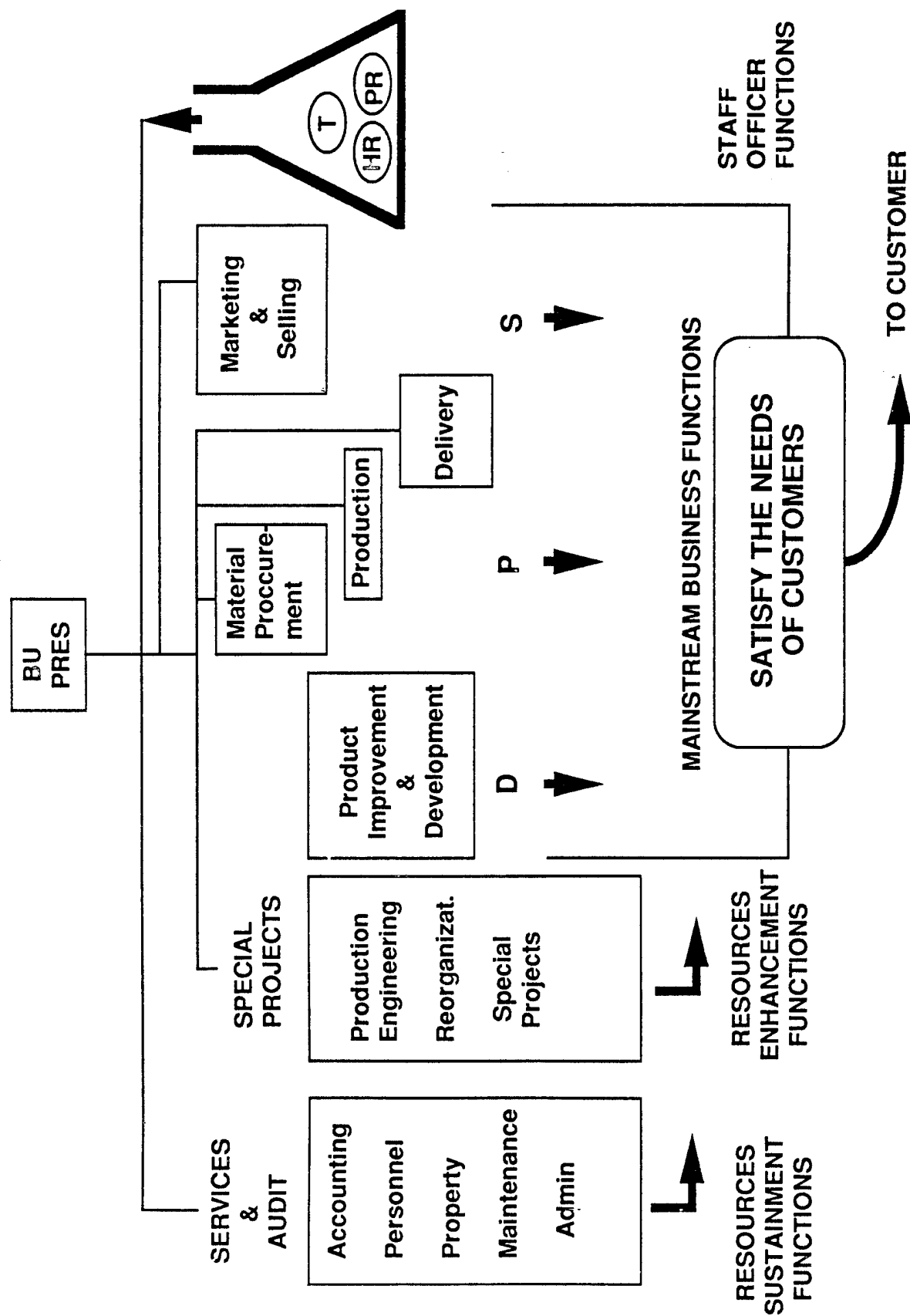


1. Maintain a competitive entrepreneurial thrust
 - lean strategic HQ
 - Business Opportunities Development Group
 - a New Ventures Group
2. Maintain an Operations Group
 - Strategic Business Units
 - Group-wide Service Units

CORPORATE FUNCTIONAL ALIGNMENT

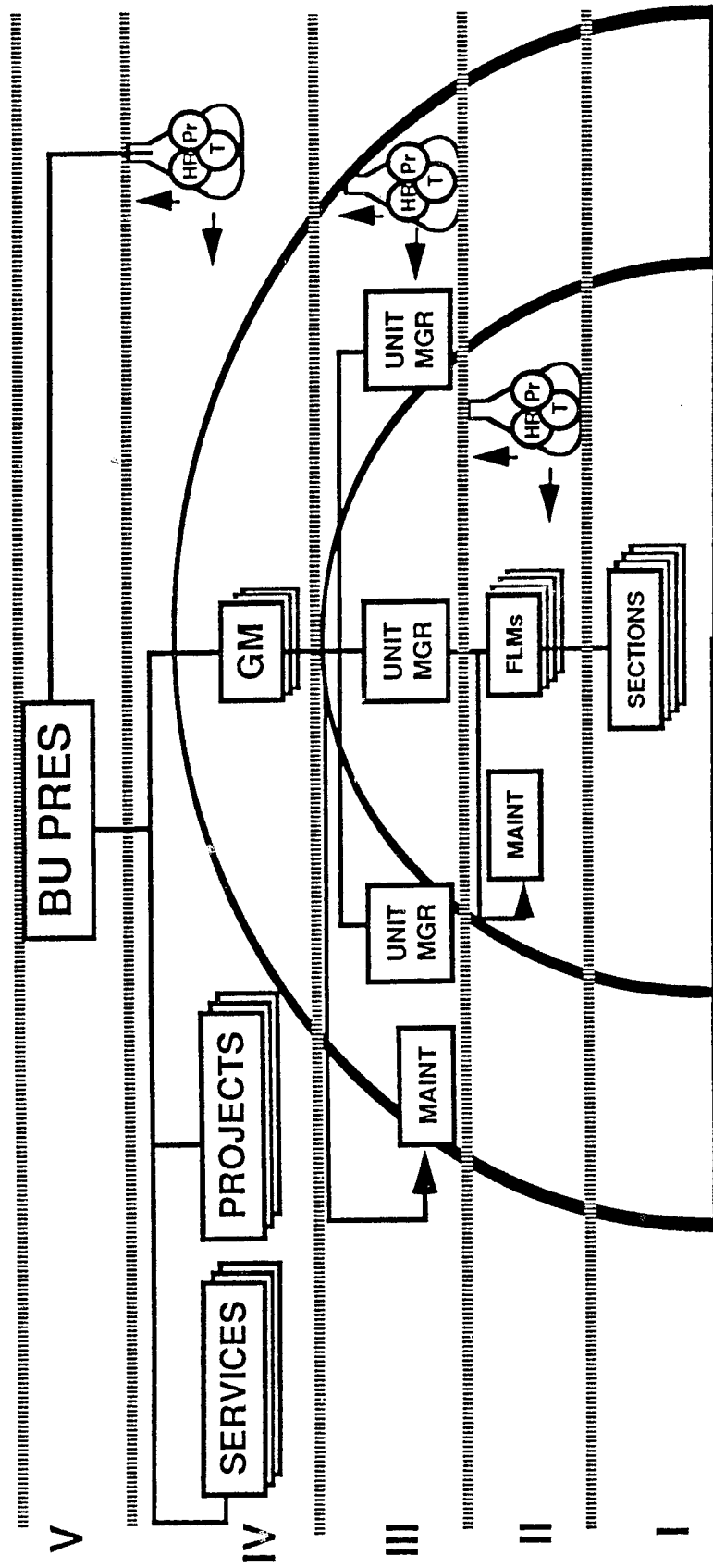


BUSINESS UNIT FUNCTIONAL MODEL



DESIGN PRINCIPLE #5

BUSINESS UNIT MODEL



DESIGN PRINCIPLE # 7

FOR ANY GIVEN ROLE, DETERMINE IF THE ROLE OUTPUTS ARE: 1. TO BE SENT OUT FROM THAT LEVEL (DIRECT OUTPUT, 2. MAJOR OUTPUTS DELEGATED DOWNWARD, (DDO), OR IF THE OUTPUTS ARE TO BE SENT UPWARDS (DOS)

DIRECT OUTPUT (DO)

Output which is signed of directly and sent neither up nor down

DELEGATED DIRECT OUTPUT (DDO)

Outputs which are assigned to be produced and sent out at subordinate levels

DIRECT OUTPUT SUPPORT

Support given by a subordinate to assist their manager with the manager's own direct output

DESIGN PRINCIPLE #7

FOR ANY GIVEN ROLE, DETERMINE IF THE ROLE OUTPUTS ARE: 1. TO BE SENT OUT FROM THAT LEVEL (DIRECT OUTPUT), 2. MAJOR OUTPUTS DELEGATED DOWNWARD, (DDO), OR IF THE OUTPUTS ARE TO BE SENT UPWARDS (DOS)

DIRECT OUTPUT (DO) - Output which is signed off directly and sent neither up nor down

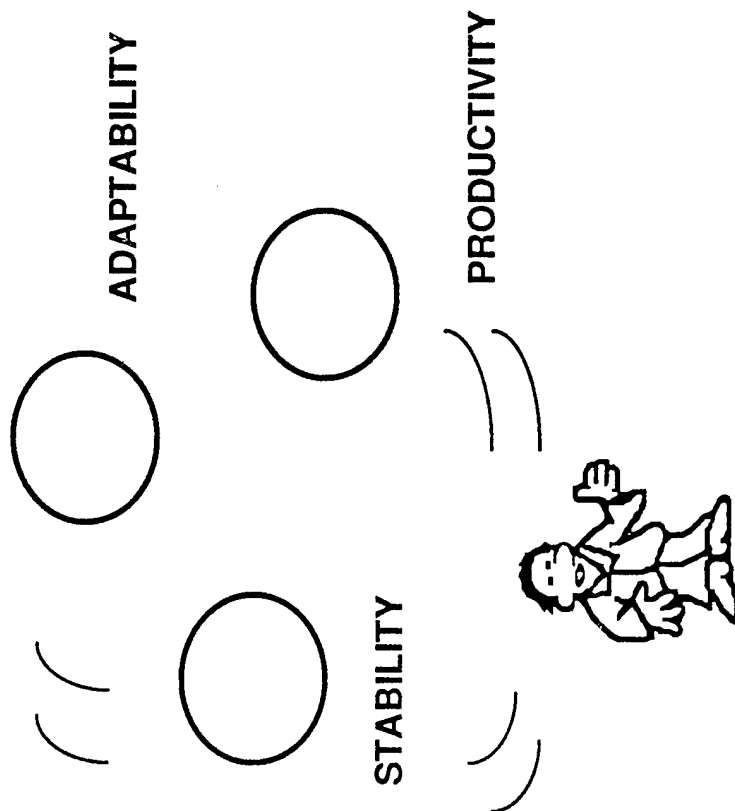
DELEGATED DIRECT OUTPUT (DDO) - Outputs which are assigned to be produced and sent out at subordinate levels

DIRECT OUTPUT SUPPORT (DOS) - Support given by a subordinate to assist their manager with the manager's own direct output

POLICY CONTROLLED DIRECT OUTPUT _ The direct output of a subordinate which must be checked with a superior to ensure that it is within policy limits, before being signed off

	CD WORK	DOCTRINE WORK	TRAINING WORK	LOG WORK
DO				
DOS	DO		DDO	DDO

TRADOC MISSION:
SATISFYING THE
NEEDS OF CUSTOMERS



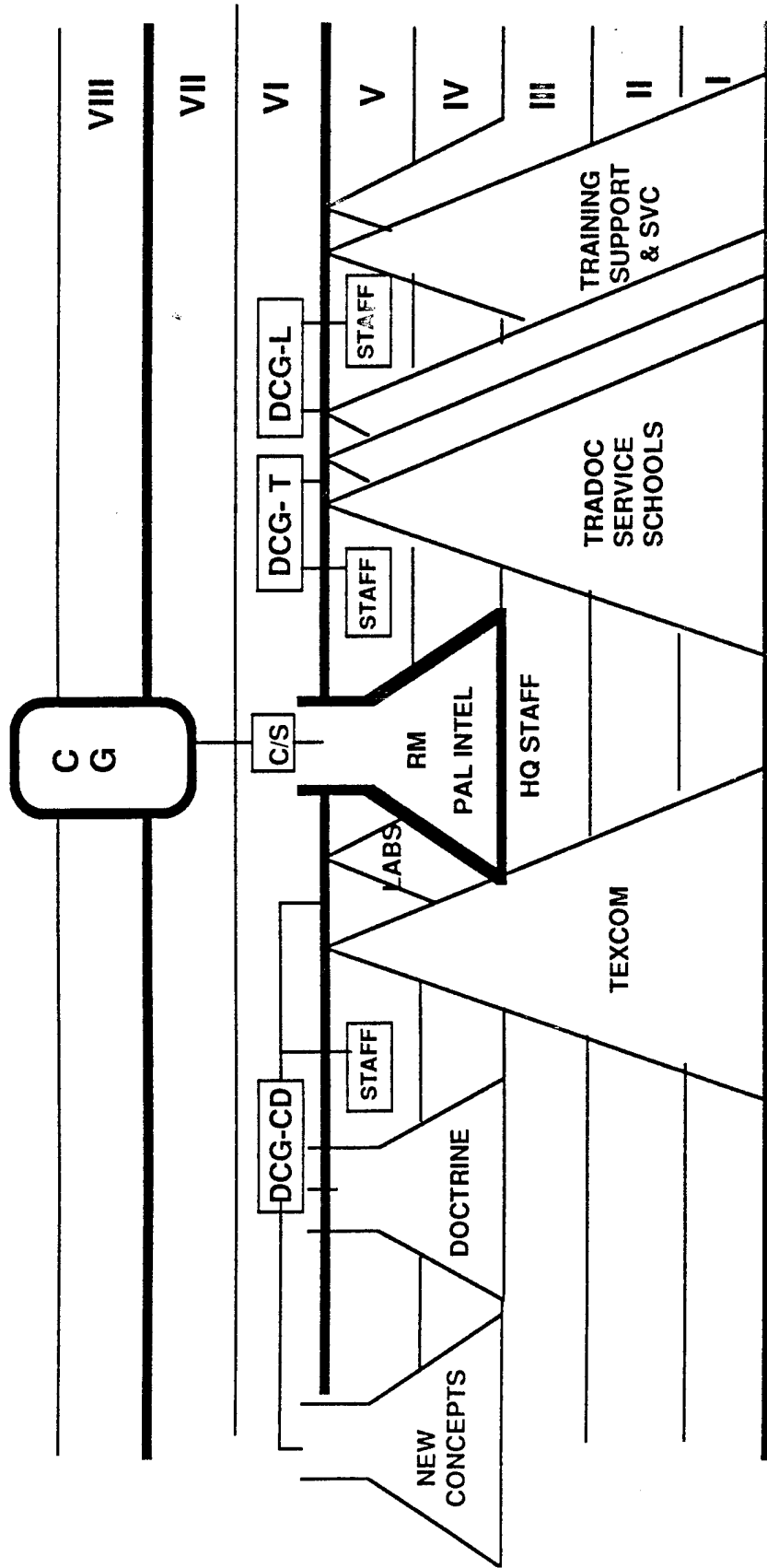
MAJOR MISSION AREAS

1. TRAINING
2. EQUIPMENT REQUIREMENTS
3. FORCE DESIGN
4. DOCTRINE
5. MISSION SUPPORT
6. LEADER DEVELOPMENT

THE CG AT WORK

ORGANIZATIONAL
DESIGN INC. 1993

TRADOC FUNCTIONAL ALIGNMENT

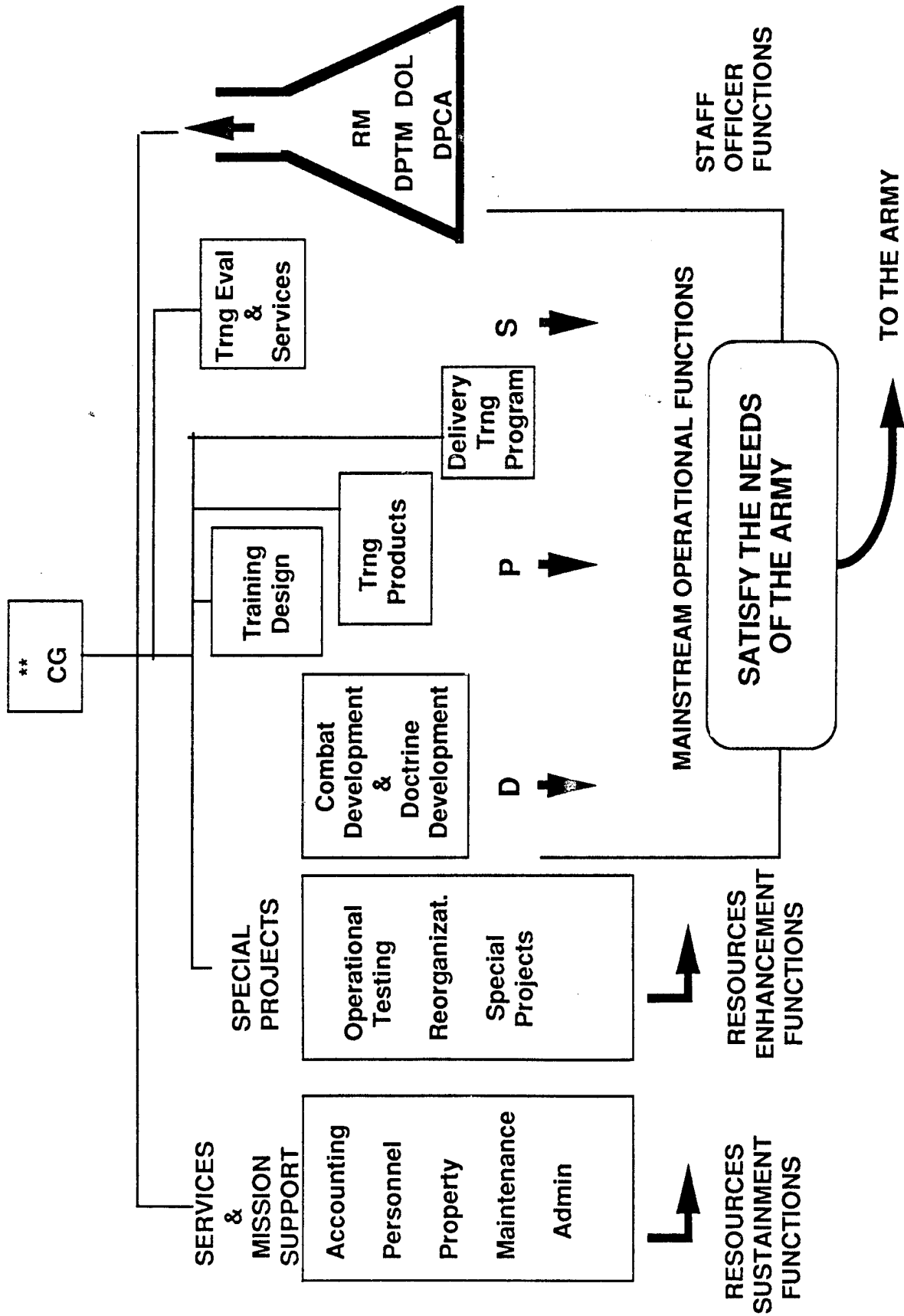


"THE FUTURE"
ARMY WIDE FOCUS

OPERATIONS
IMPROVEMENT OF CURRENT OPS & SVCS

ORGANIZATIONAL
DESIGN INC. 1993

SCHOOL FUNCTIONAL MODEL



PROPERTIES OF ROLES

1. ACCOUNTABILITY

2. AUTHORITY

ORGANIZATIONAL LEADERSHIP

TYPES OF ROLES

1. MANAGERIAL
2. STAFF
3. SUPPORT
4. INDEPENDENT CONTRIBUTOR
5. PROJECT MANAGER
6. MANAGER-ONCE-REMOVED

ROLE ACCOUNTABILITY FORMAT

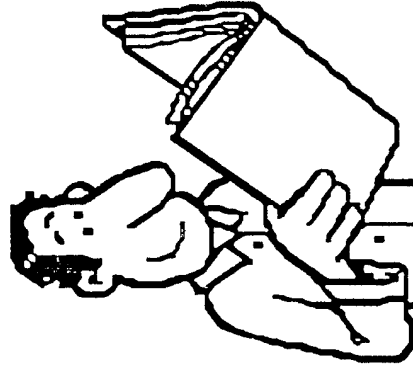
**1. GENERAL ACCOUNTABILITY
STATEMENT**

**2. SPECIFIC WORK RELATED
FUNCTIONS**

3. OUTPUTS TO BE PRODUCED

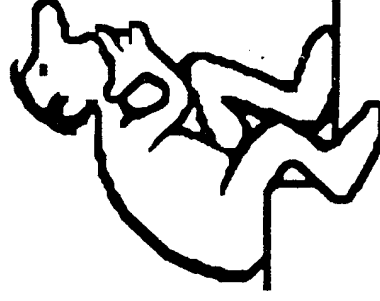
4. WORKING RELATIONSHIPS

DEVELOPING ROLES



DESIGN BASED

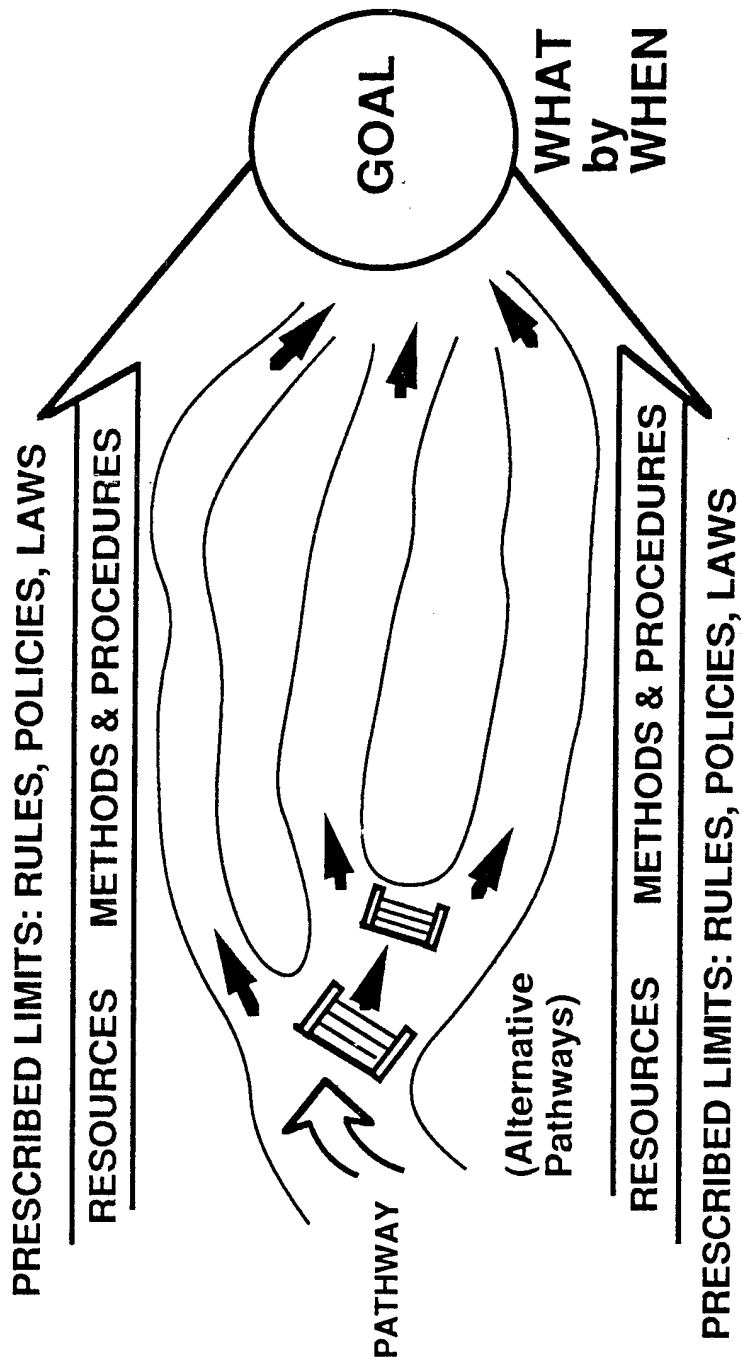
- CLEAR FUNCTIONS
- CUSTOMER FOCUSED
- APPROPRIATE LIMITS
- ADEQUATE AUTHORITY



INDIVIDUAL BASED

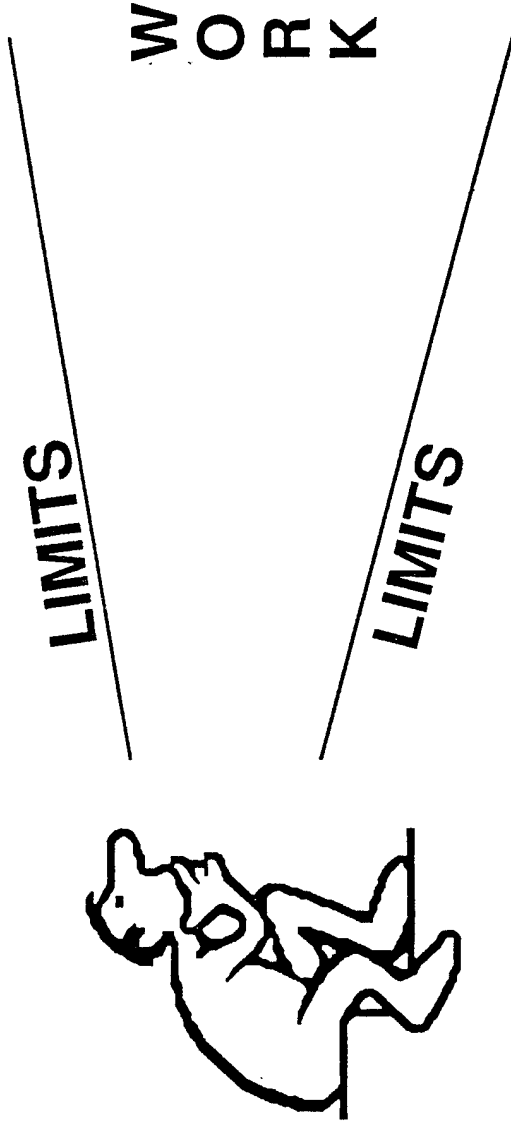
- UNCLEAR RESPONSIBILITIES
- INADEQUATE CUSTOMER FOCUS
- UNSPECIFIED LIMITS
- AUTHORITY ILL DEFINED

WORK LIMITS



ORGANIZATIONAL
DESIGN INC. 1993

WORK EXPANSION



PRINCIPLE; In the absence of clear limits and specific accountabilities, highly capable people will expand their focus in order to work to their full potential

25

ROLE RELATIONSHIPS HOW PEOPLE WORK TOGETHER"

Role relationships contain the volatile ingredients of interacting accountabilities and authorities.

The precise nature of these accountabilities and authorities are rarely specified.

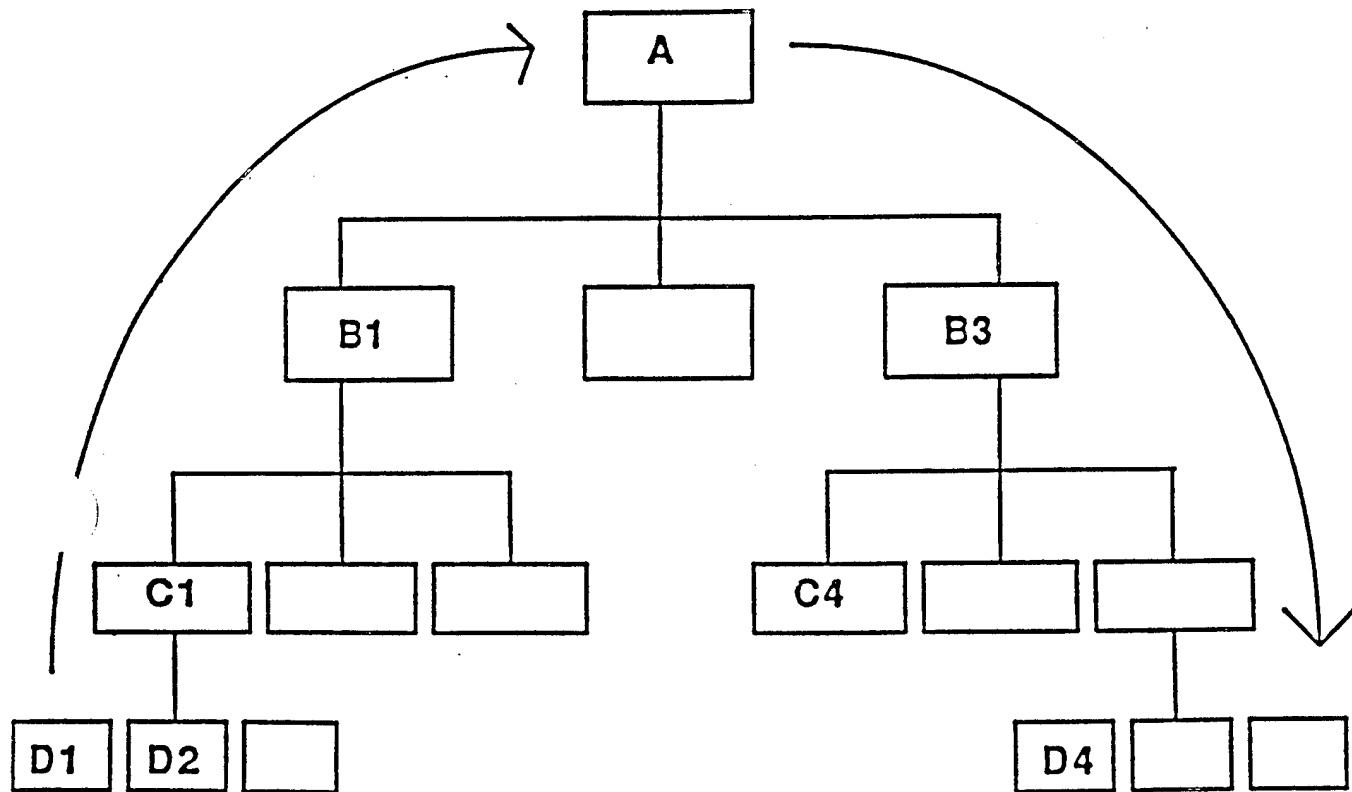
In the absence of specification, individuals make their own rules about what they can and cannot do in relation to one another. Some people may "pussyfoot" while others throw their weight around. This can easily lead to a chronic undertow of unease and vague suspicion which can grow into downright mistrust.

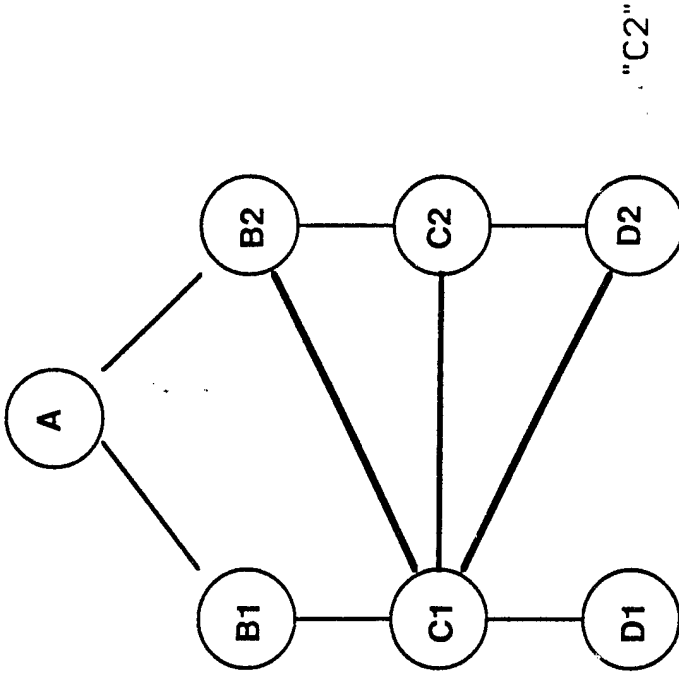
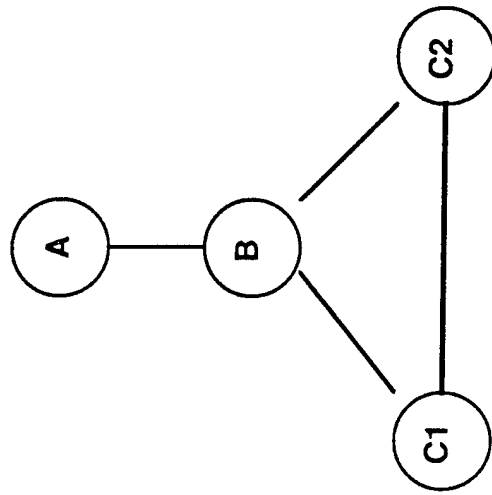
This has encouraged an unrealistic behavioral approach to organization, in which conflict and inefficiency are explained in terms of the motives and personalities of the individuals concerned.

Organizational Development is perceived in terms of quasi-psychotherapeutic approaches designed to change the attitudes and behavior of individuals and how they cope with authority, power and conflict.

**THE SOLUTION IS TO ESTABLISH THE REQUIRED
ACCOUNTABILITY AND AUTHORITY CONTEXT FOR
ALL ROLES THROUGHOUT THE ORGANIZATION**

TASK ASSIGNING TRADITIONAL WORK SYSTEM





TASK INITIATING ROLE RELATIONSHIPS

ORGANIZATIONAL
DESIGN INC. 1993

COLLABORATIVE ROLE RELATIONSHIPS: SUMMARY

ACCOUNTABILITY & AUTHORITY

	ADVISORY	MONITORING	CO-ORDINATIVE	AUDIT/INSPECT	*PRESCRIBE	COLLATERAL	SERVICE GETTING
C1 CAN BE INFORMED ABOUT C2'S WORK	✓	✓	✓	✓	✓	✓	✓
C1 CAN HAVE ACCESS TO PERSUADE C2	✓	✓	✓	✓	✓	✓	✓
C1 CAN REPORT HIGHER ABOUT C2		✓	✓	✓	✓	✓	✓
C1 CAN INSTRUCT C2 TO DELAY AND C2 DELAYS		✓	✓	✓	✓		
C1 CAN CALL CO-ORDINATIVE MEETING WITH C2 'S			✓		✓		
C1 CAN INSTRUCT C2 TO STOP AND C2 STOPS					✓		
C1 CAN INSTRUCT C2 TO DO SOMETHING					✓		✓

LEADERSHIP COMPETENCE

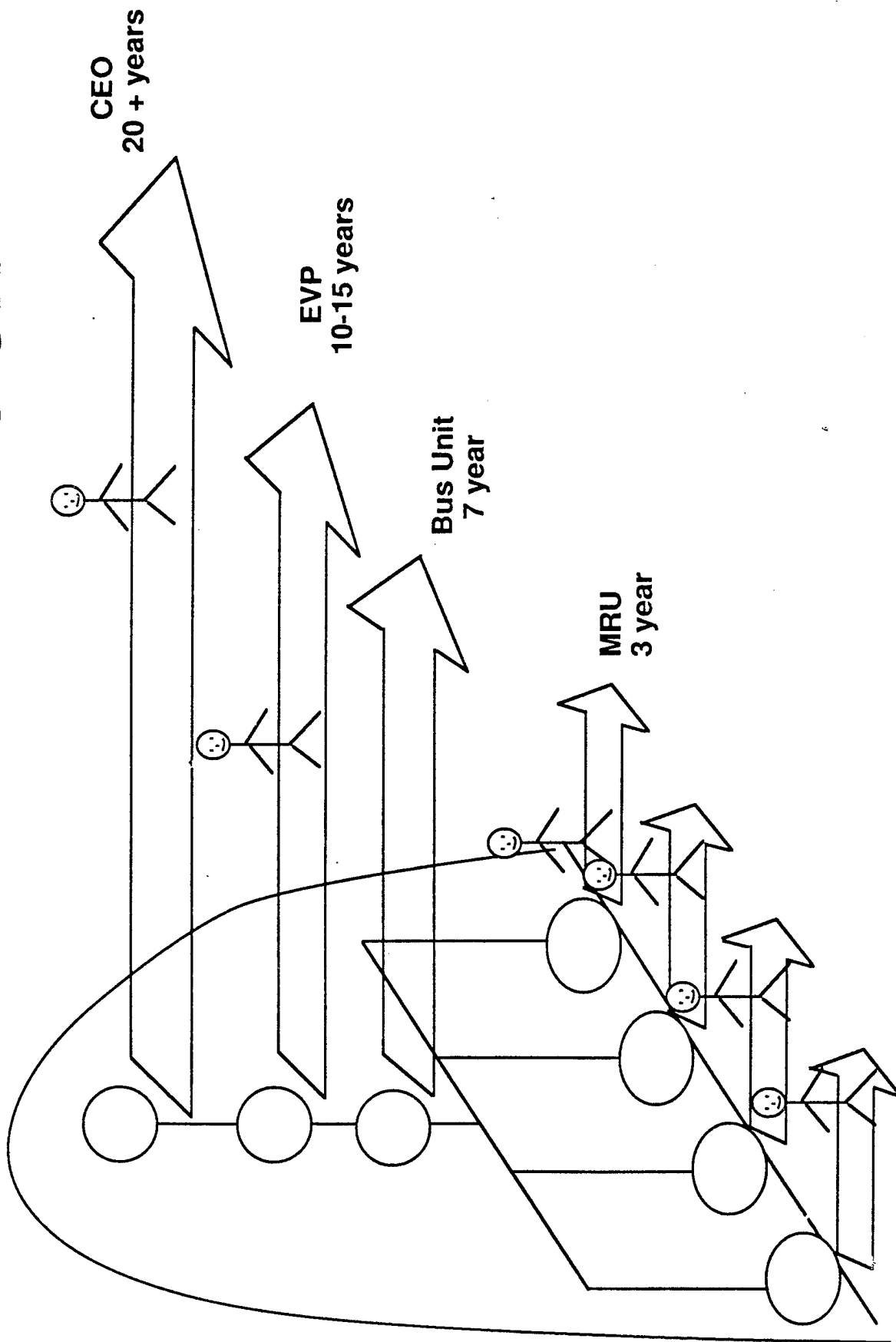
**EVERYONE IS CAPABLE OF
EXERCISING EFFECTIVE
LEADERSHIP ACCOUNTABILITY**

- SO LONG AS THEY VALUE THE
ROLE**
- ARE COMPETENT TO CARRY
OUT THE BASIC REQUIREMENTS
OF THE ROLE**

LEADERSHIP DEFINITION

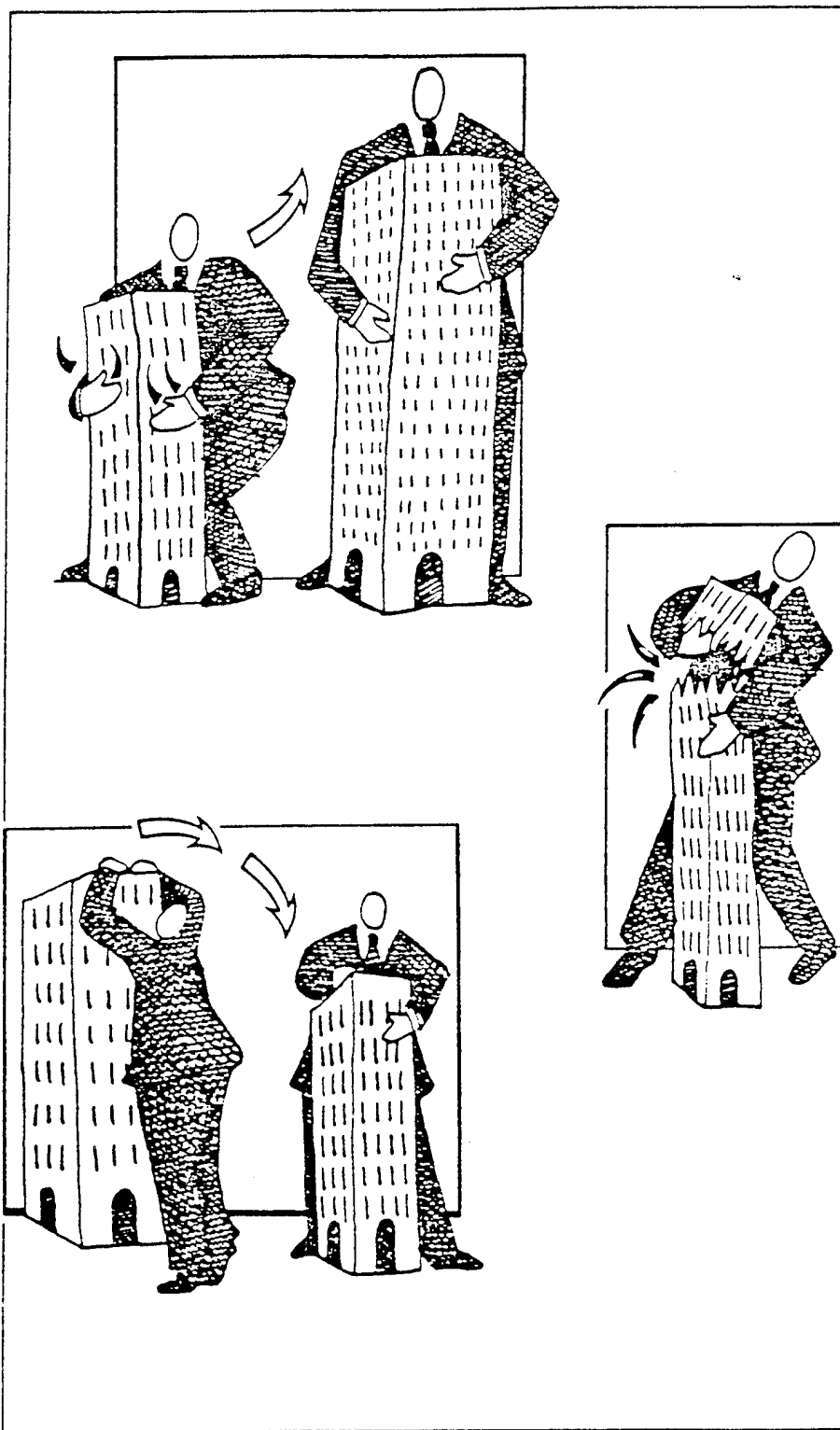
Leadership is the process where one person sets the purpose or direction for one or more other persons, and gets them to move along together with him or her and with each other in that direction with competence and full commitment

SETTING THE VISION

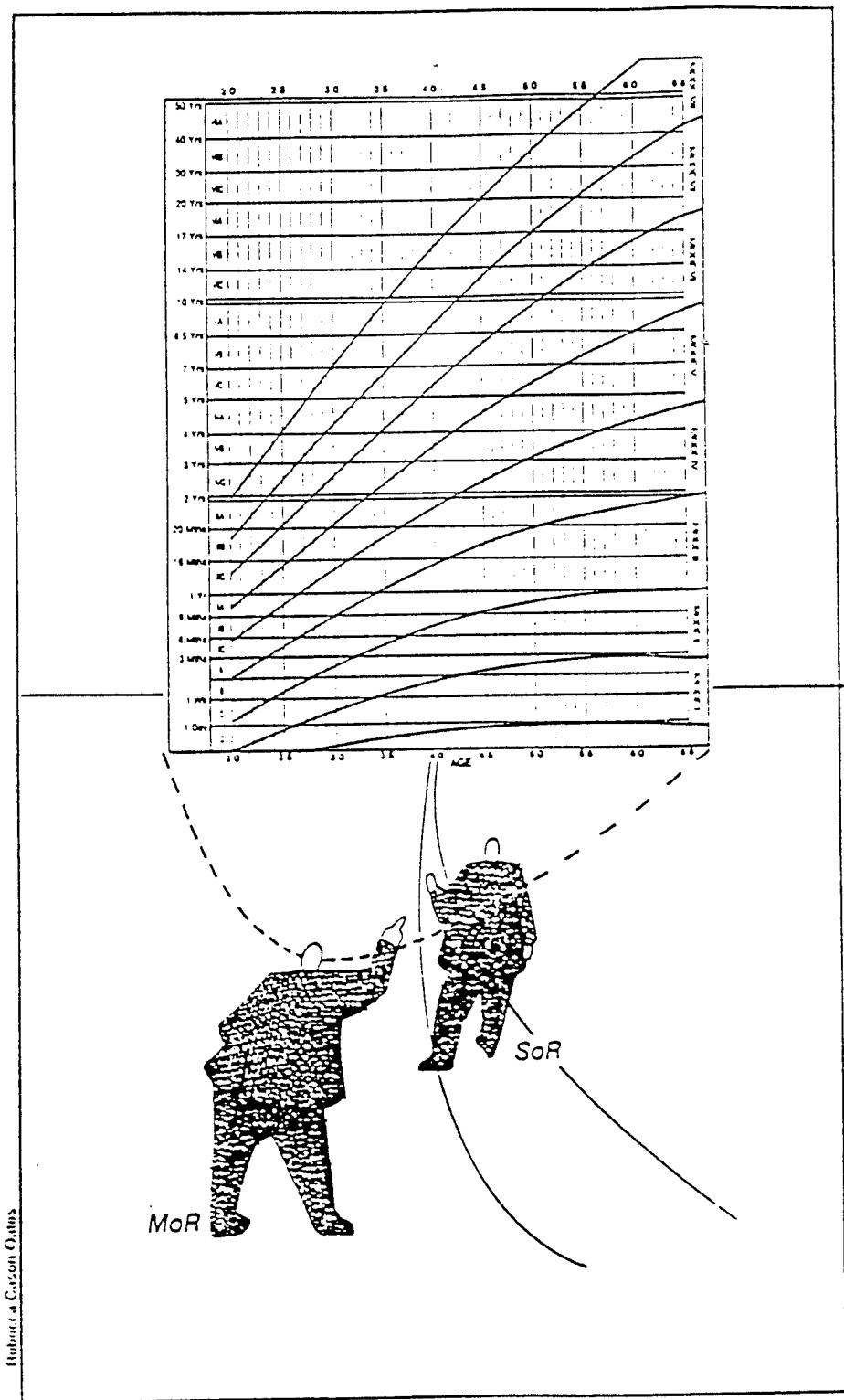


MANAGERIAL PRACTICES

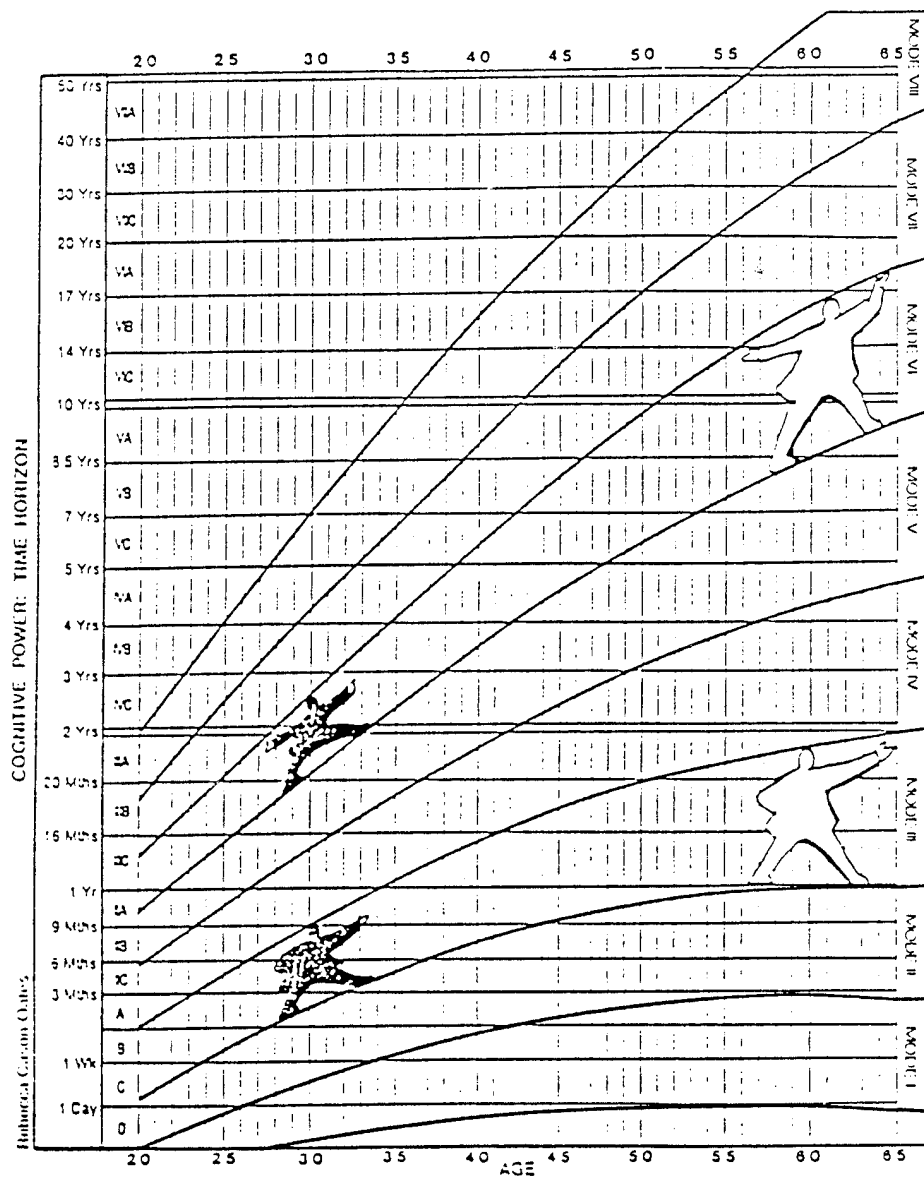
**Planning
Task Formulation & Assignment
Personal Effectiveness Appraisal
Coaching
Training
Recognition, Penalties & Dismissal
Remuneration
Selection
Induction
Deselection
Retrenchment & Downsizing**

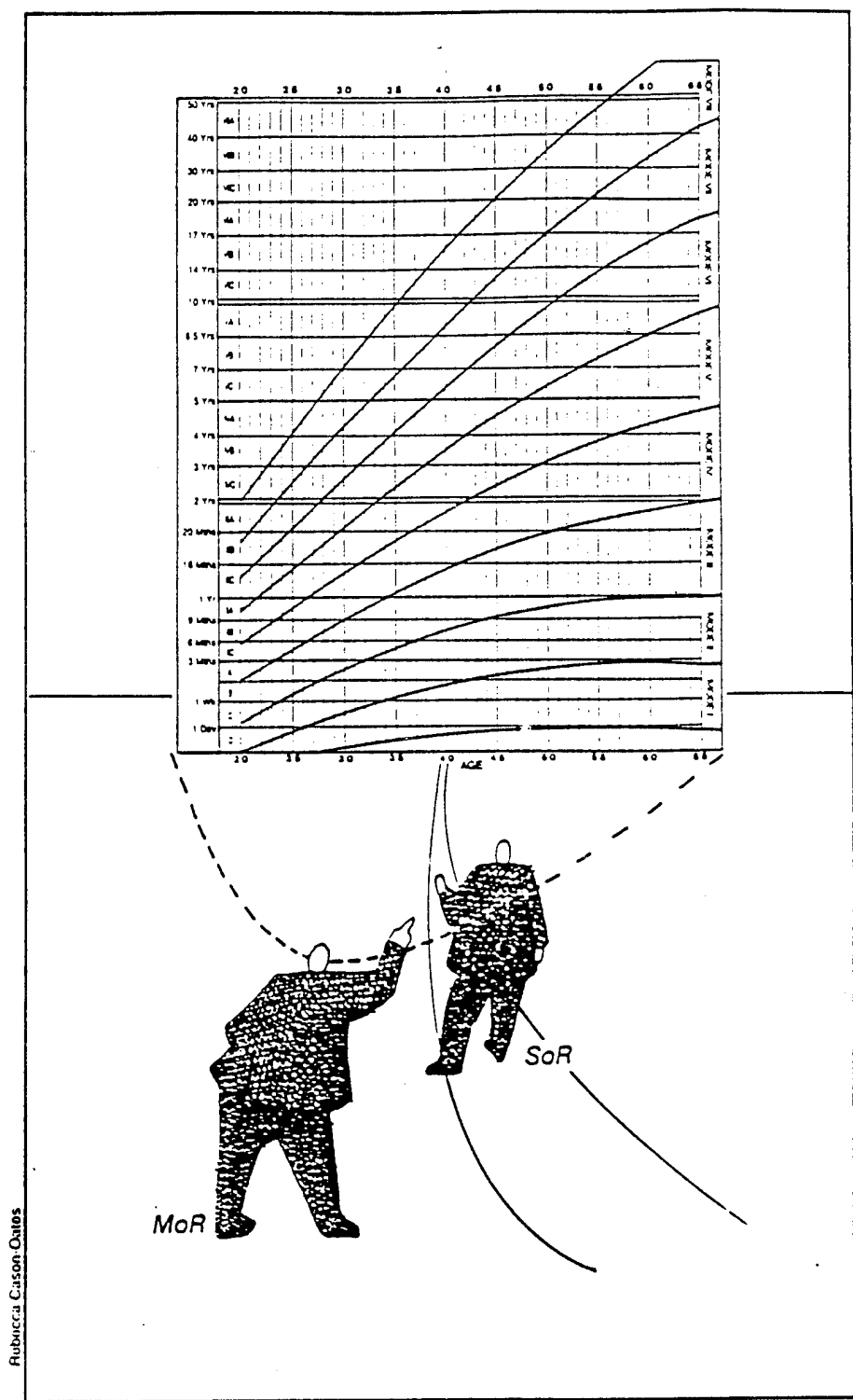


Roberta Carson Oates



Robert A. Carson Obit





Rubrica Cason-Ostos

PROJECT TEAMS AND EXPERT LEADERSHIP

241

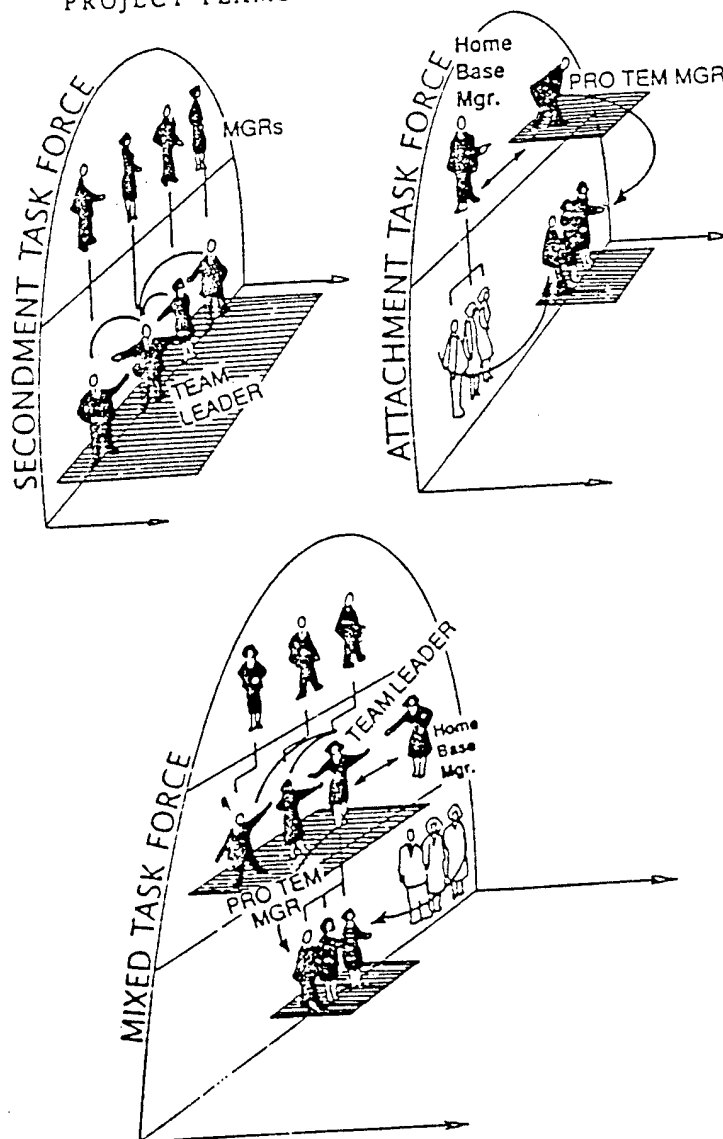
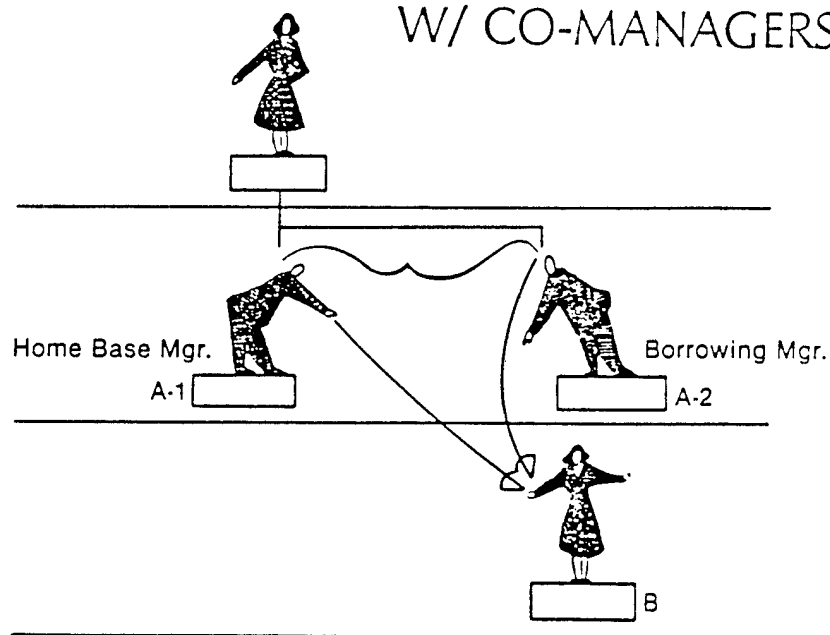


Figure 8.1 Project teams

ATTACHMENT W/ CO-MANAGERS



Rebecca Cason-Oates

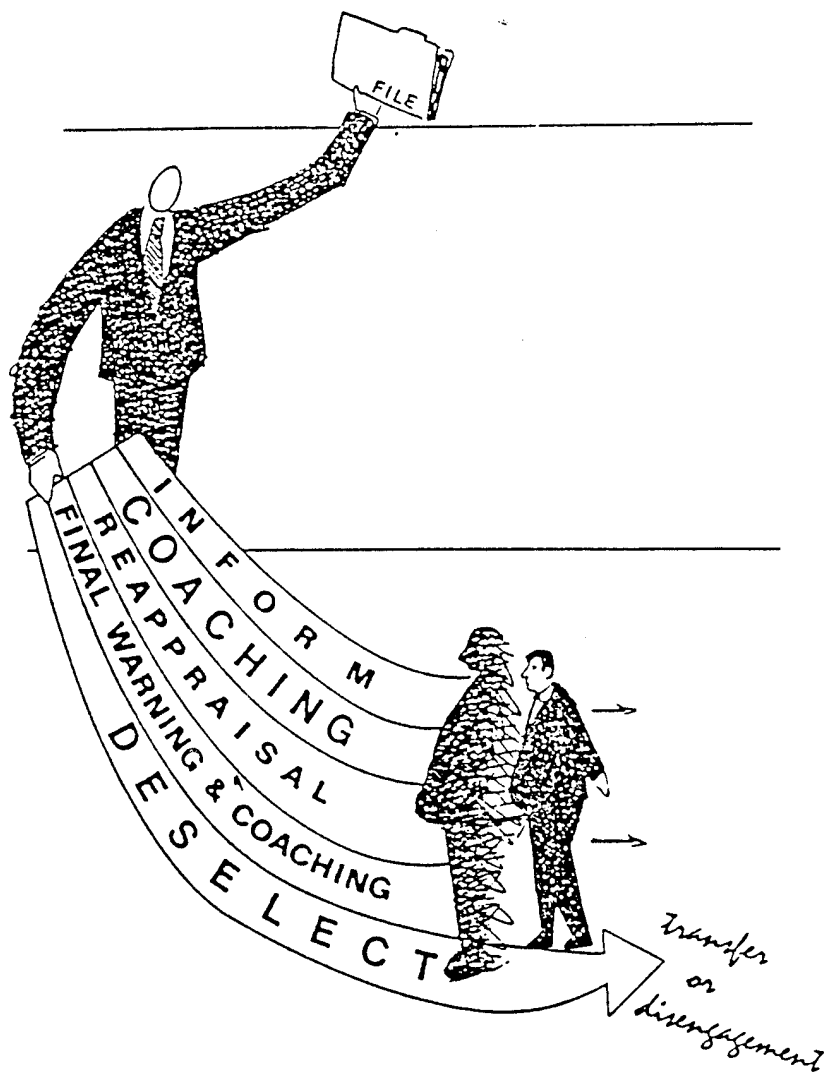


Figure 6.18 Deselection

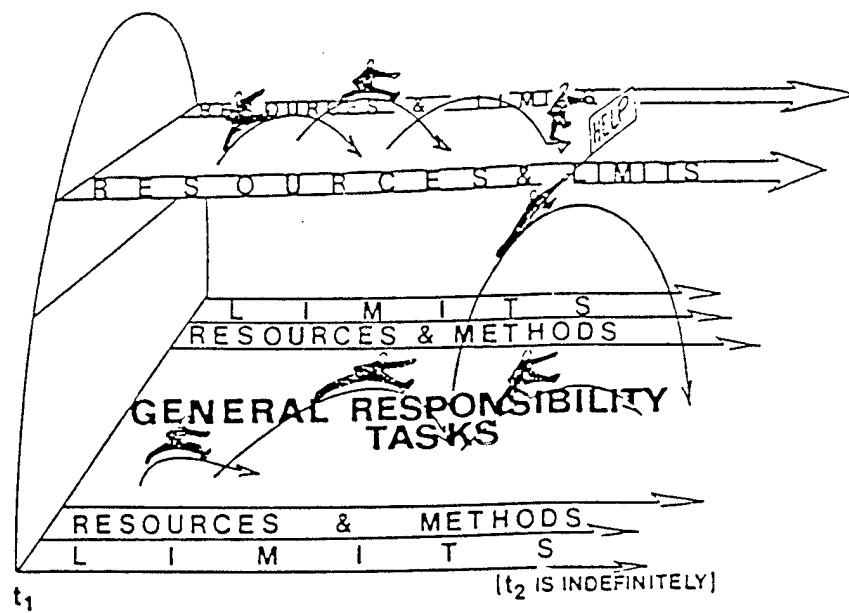


Figure 6.4 General responsibilities

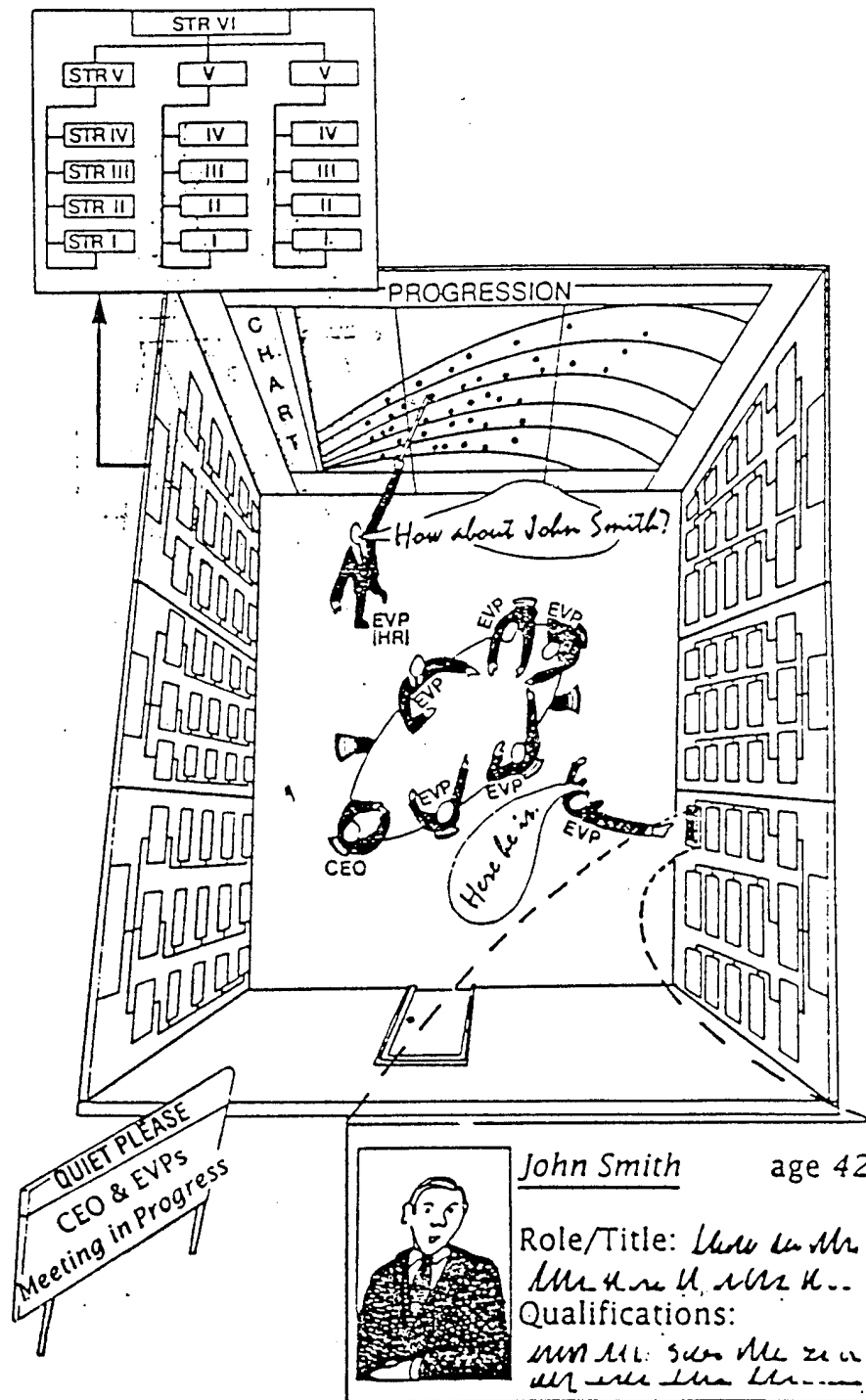
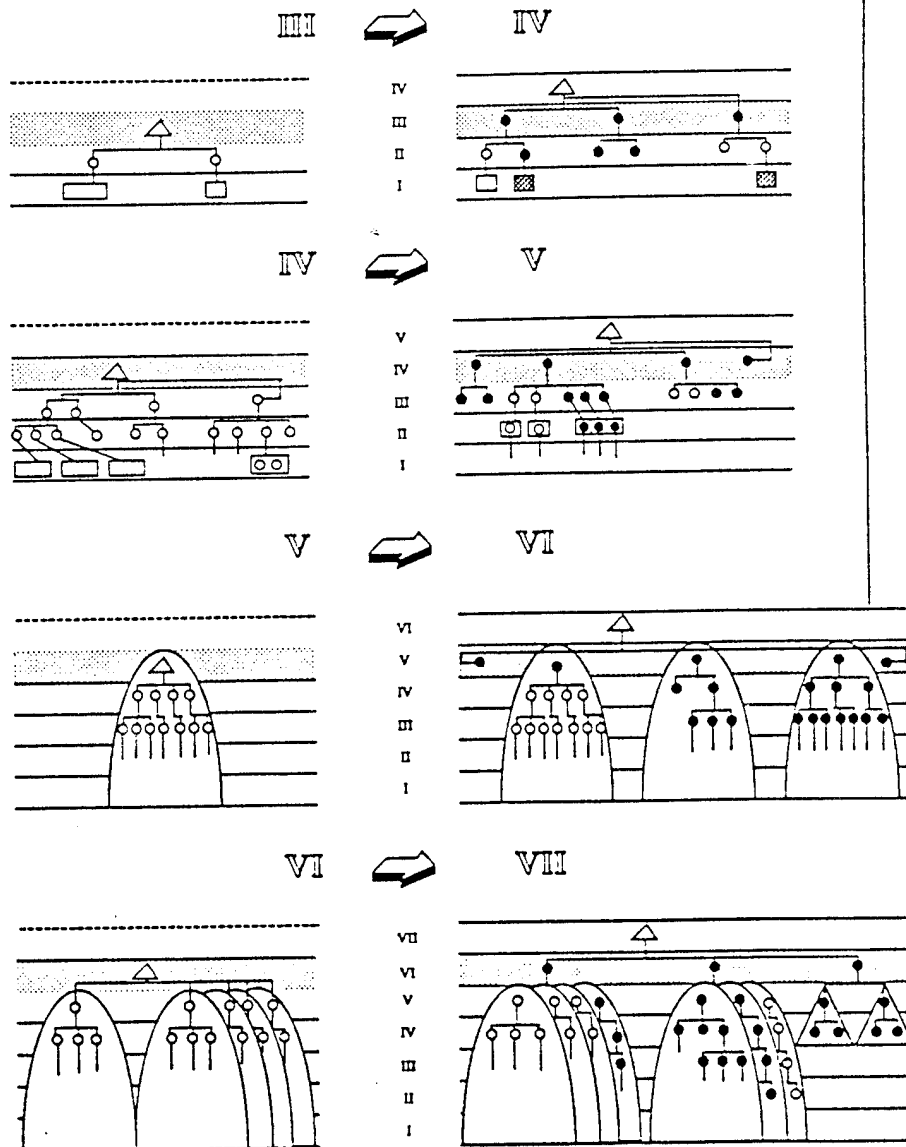


Figure 11.1 CEO's managerial leadership talent pool control room

What happens when the CEO moves up?



The stratum the CEO steps up from (shaded) becomes empty, and requires an entirely new set of roles at that stratum.

- New Role
- Continuing Role

THE CHALLENGE

HOW TO WORK SMARTER

NOT

WORK HARDER

ORGANIZATIONAL
DESIGN INC. 1993

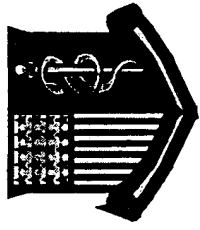
ENCLOSURE 5

IPR for The Surgeon General



"Knocking Off the Big Chunks"

Task Force Aesculapius



Purpose of IPR

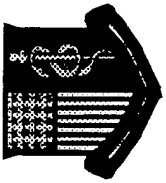


- Present Aesculapius' position on major decision points
- Obtain TSG commitment
- Reduce options and refine plans
- Provide AcHs planning and action context
- Jaques: Intensify relationship between TSG and TFA

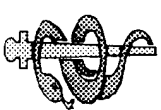


Major Decision Points

- ARSTAF
 - ▶ Location and Functions
- MEDCOM
 - ▶ Formation and Location
 - ▶ CDR Rank and Location
 - ▶ Functions
- REGIONS
 - ▶ Number and Report Chain
 - ▶ CDR Rank
 - ▶ Functions
- MEDCOM CDR - TSG Permutations



ARSTAF



DECISION POINT

AESCULAPIUS' POSITION

LOCATION

PENTAGON

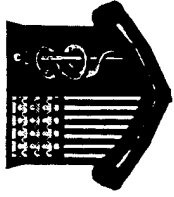
SIZE

LESS THAN 100

FUNCTIONS

PAT

REQUISITE STAFF



ARSTAF PROS



- Integrates & focuses staff actions & info exchange
- AMEDD only ARSTAF element not in Pentagon
- Increased visibility--Army & DOD(HA)
- Save \$1.425M rent; other overhead cost savings



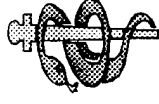
ARSTAF CONS



- Potentially less responsive administrative support
- Cost and downtime of OTSG staff during move



MEDCOM



DECISION POINT

AESCULAPIUS' POSITION

FORMATION

MELD OTSG, HFPA, HSC

LOCATION

FT SAM HOUSTON

CDR RANK

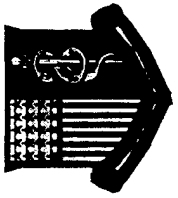
LTG

CDR LOCATION

FT SAM HOUSTON

FUNCTIONS

PAT



MEDCOM PROS



- Unity of command
- Reduces duplication & layering
- Paradigm I, II, III integration
- Not seen as "Business as Usual"
- Win - win: No losers thru "transformation"
- Places MEDCOM at locus of operations
- Moves assets from NCR



MEDCOM PROS

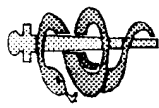
(continued)

- Enhances Fort Sam as "AMEDD Center of Gravity"
 - ▶ clearly shifts operational base from NCR
 - ▶ space available after new BAMC opens
- Better platform to assume j-MEDCOM role under DHA
 - ▶ seen as separate from Army TSG office
 - ▶ DOD(HA) likes HSC model - this supercharges it
- Provides LTG MACOM voice to Chief of Staff





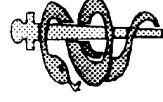
MEDCOM CONS



- HSC system working well enough
- Significant personnel turbulence- may trigger AR5-10
- May require new/renovated facility
- Requires Army Staff culture change
- Special interest concerns about move from NCR
- AMEDD influence in NCR
- May require change to Title 10, USC



REGIONS



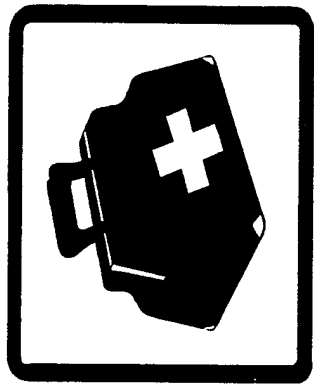
DECISION POINT	AESCULAPIUS' POSITION
----------------	-----------------------

NUMBER	4: CORPS + WRAMC
--------	------------------

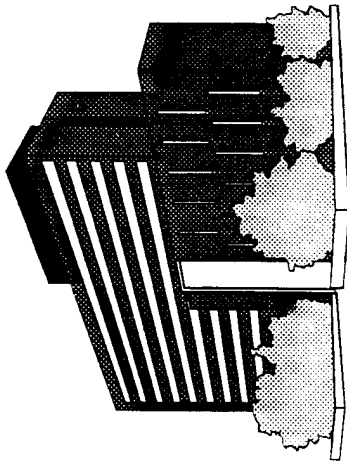
REPORT TO	MEDCOM DIRECTLY
-----------	-----------------

CDR RANK	GENERAL OFFICER
----------	-----------------

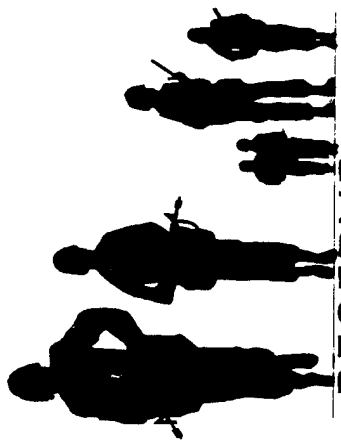
FUNCTIONS	PAT
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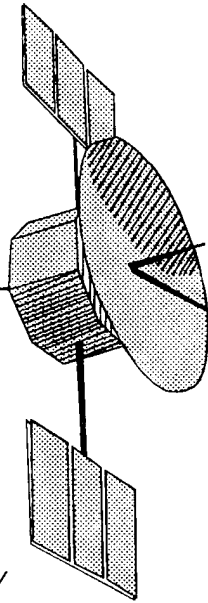
MTFs



CIVILIAN
HEALTHCARE
ASSETS

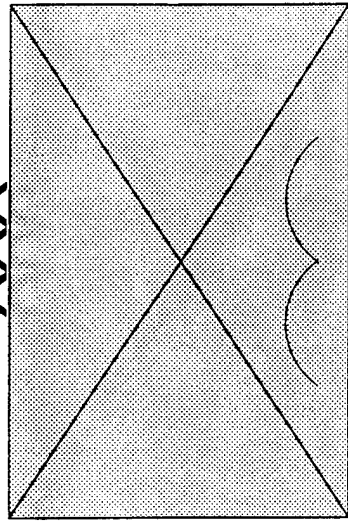


RESERVE
COMPONENTS



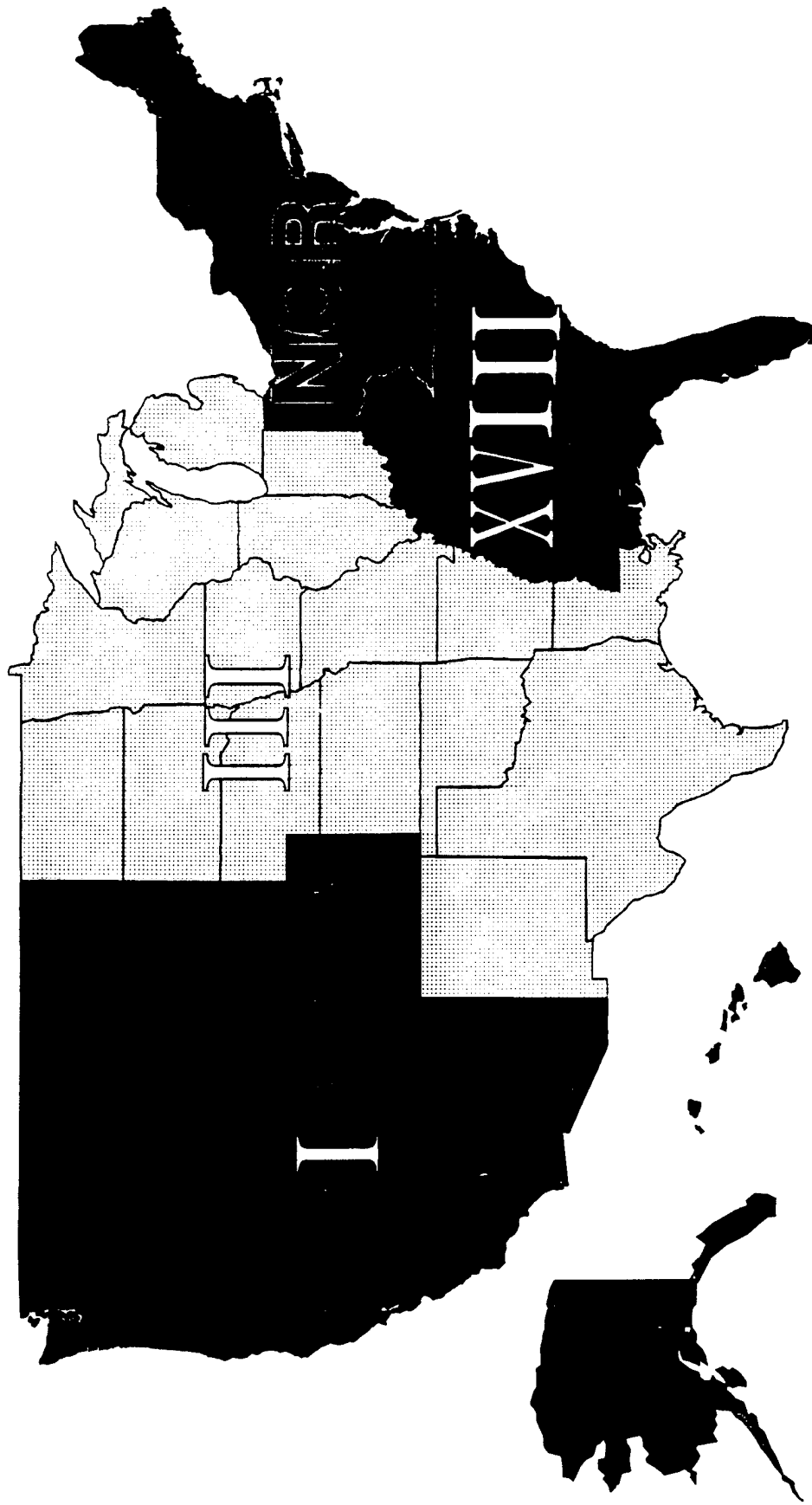
REGIONS

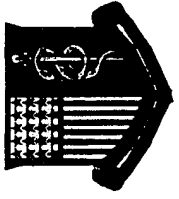
XXX





REGIONAL CONCEPT





Region PROs



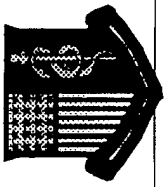
- Aligns AMEDD with warfighting corps
- Reduces layering
- Improves planning & execution
- Integrates Paradigms I, II, III
- Provides framework for expanded AMEDD role under DHA



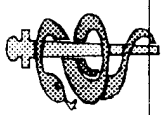
Region CONS



- HSC "good enough"
- Redistribution of assets
- Additional space/facility for region HQs
- Shift in leader development
- Moving GOs



CDR/TSG PERMUTATIONS



- CDR IS LTG; TSG IS MG
- LTG DUAL HATS; DSG RUNS ARSTAF

MEDCOM CDR - TSG Permutations

CDR is LTG/TSG is MG

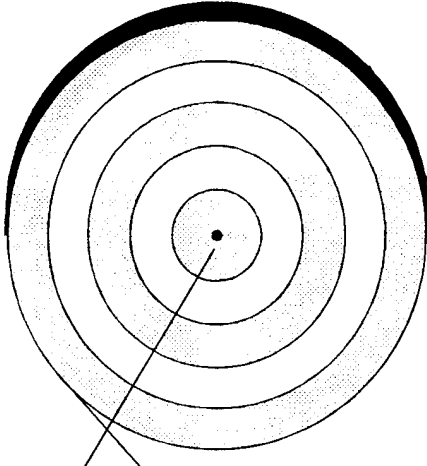
- PROS
 - ▶ Commanders report to Commander
 - ▶ Separates policy from operations
 - ▶ Eliminates permanent "Acting" title
 - ▶ Doesn't waste star in position that does not control \$ and people
 - ▶ Clarifies "who's in charge"
- CONS
 - ▶ requires Title 10 change

MEDCOM CDR - TSG Permutations

LTG dual-hats/DSG runs ARSTAF

- PROS
 - ▶ Commanders report to Commander
 - ▶ Least disruptive to status quo
 - ▶ Doesn't waste star in position that does not control \$ and people
- CONS
 - ▶ Requires Title 10 change
 - ▶ Does not separate policy and operations
 - ▶ Confuses role of "who's in charge"

"PLANT SOME FLAGS"
(AIMING STAKES)
"FOCUS OUR AZMUTH"



REQUISITE AMEDD

FOUR; RPT TO MEDCOM
CDR IS GEN OFFICER

APPROPRIATE
FUNCTIONS

REGIONS

OTSG, HSC, HPSA
CDR (LTG) & CMD IN FSHT

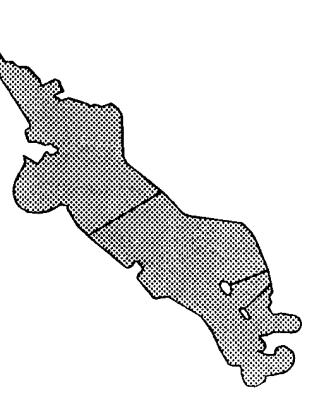
APPROPRIATE
FUNCTIONS

MEDCOM

IN THE PENTAGON
LESS THAN 100

APPROPRIATE
FUNCTIONS

ARSTAF





Summary Statements



- ARSTAF element will be in Pentagon
- MEDCOM will meld appropriate functions from OTSG, HPSA, & HSC; latter two will transform into core of MEDCOM
- MEDCOM located at Fort Sam Houston; LTG CDR also there
- There will be four regions: three aligned with warfighting corps and one centered on WRAMC
- Regions will be led by General Officers reporting directly to the MEDCOM
- Function of Regions, MEDCOM, & ARSTAF to be developed through use of PATs under Aesculapius direction
- MEDCOM CDR is senior AMEDD leader

ENCLOSURE 6



REPLY TO
ATTENTION OF

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
5109 LEESBURG PIKE
FALLS CHURCH, VA 22041-3258



DASG-HCM (10)

16 JUL 1993

MEMORANDUM FOR DEPUTY CHIEF OF STAFF FOR OPERATIONS AND PLANS

SUBJECT: Revised Concept Plan for Establishment of the US Army Medical Command

1. Request approval to realign Army Medical Department (AMEDD) activities to establish the US Army Medical Command (USAMEDCOM). A revised concept plan is enclosed.
2. This proposal requires no additional resources from HQDA. Based on Army Secretariat staff comments addressing our original submission, our proposal has been significantly altered. As recommended by Task Force Aesculapius, the concept plan now recommends inactivation of the Health Services Command, and placement of the USAMEDCOM in Fort Sam Houston, Texas, instead of the National Capital Region. This proposal has been presented to the Acting Secretary of the Army, and key Secretariat and Army Staff principals. Their feedback has been universally positive.
3. I remain committed to placing the Army Medical Department on the proper path to enhance support of Army readiness and preserve the health of all eligible beneficiaries. On 8 July 1993, the Director of the Army Staff requested I submit the concept plan to the ARSTAF for formal staffing, with the objective of presenting to the Acting Secretary of the Army our proposal for formal decision by the end of July 1993. It is my goal to obtain approval to establish the command provisionally by 1 October 1993. Your assistance in facilitating this effort is greatly appreciated.
4. If you have any questions on the concept plan and the proposed realignment, please call me or my points of contact, COL Herb Coley or Mr. Maurice Yaglom, DASG-HCM, 756-0305.

ALCIDE M. LANOUE
Lieutenant General
The Surgeon General

Encl
as

CONCEPT PLAN FOR ESTABLISHMENT OF
THE
US ARMY MEDICAL COMMAND

1. Subject. Concept Plan - Establishment of the US Army Medical Command.

2. Threshold event/added resources. Concept plan proposes establishment of the US Army Medical Command (USAMEDCOM), FT Sam Houston, Texas, with The Surgeon General (TSG) dual hatted as Commander. The US Army Health Services Command (USAHSC), FT Sam Houston, Texas, and the US Army Health Professional Support Agency, Falls Church, Virginia, are inactivated. Proposal includes activation of the US Army Dental Command, FT Sam Houston, Texas, and the US Army Veterinary Command, FT Sam Houston, Texas as subordinate commands within USAMEDCOM. The Army Medical Department (AMEDD) Center and School, FT Sam Houston, Texas, and the US Army Environmental Hygiene Agency, Aberdeen Proving Ground, Maryland, would also be realigned as subordinate commands of USAMEDCOM. The concept plan also includes aligning the US Army Medical Research and Development Command (USAMRDC), FT Detrick, Maryland, the US Army Medical Materiel Agency (USAMMA), FT Detrick, Maryland, and the US Army Health Facility Planning Agency (USAHFPA), Falls Church, Virginia, within the USAMEDCOM. A separate proposal to merge USAMRDC, USAMMA, and USAHFPA to establish the US Army Medical Materiel Command will be forwarded at a future date for assessment. Similarly, the activation of six Health Service Support Areas (HSSA) will be proposed in a later submission. Implementation is not contingent on receiving additional resources from HQDA.

3. Background. TSG is informally recognized and held accountable as the overall manager of the AMEDD, but has limited command authority to effect change. Within CONUS, the USAHSC has command operational responsibility for health care delivery. As a result, the roles and responsibilities assigned to the Office of The Surgeon General (OTSG) and USAHSC often conflict, resulting in decentralized focus, reduced accountability, and lack of unity. On 4 October 1990, the Secretary of the Army (SECARMY) accepted in concept a TSG proposal to centralize accountability for health care delivery by establishing a medical command in the NCR, with TSG dual hatted as commander. In addition, the SECARMY approved the initiation of a formal realignment study under the provisions of AR 5-10 to assess this proposal and other alternatives. A concept plan reflecting the recommendations of the realignment study was forwarded to HQDA in December 1992. Although the majority of Secretariat and ARSTAF offices concurred with TSG assuming command, concern was expressed with the proposed retention of USAHSC and the perception of "layering." Based on these comments and other on-going issues regarding proposals to

reform the nation's health care system, Task Force Aesculapius, a special study group sanctioned by the VCSA, was established to reassess the original proposal to restructure the Army Medical Department (AMEDD). Based on the recommendations of this task force, the original concept plan has been revised. See enclosure 1 for additional background and a copy of the briefing presented to the Director of the Army Staff and the ARSTAF principals on 8 July 1993. Since Task Force Aesculapius continues to refine its recommendations, there have been minor changes to the study results since that briefing. Therefore, the audit trails in the briefing might differ from those in this concept plan. The concept plan is the authoritative source of the audit trails.

4. Purpose. The purpose of this concept plan is to obtain HQDA approval to realign AMEDD activities in order to establish the USAMEDCOM, headquartered in FT Sam Houston, Texas, with TSG dual hatted as Commander, effective on 1 October 1994. Approval is further requested to establish the command provisionally by 1 October 1993.

5. Objectives. The following actions are to be accomplished:

a. Falls Church, Virginia.

(1) The OTSG ARSTAF will be reorganized to reflect the recommendation of the HQDA Transformation Study to downsize from 124 manpower authorizations in FY 94, to 102 in FY 96/97.

(2) The US Army Health Professional Support Agency will be inactivated, with selected functions transferring either to the OTSG ARSTAF; Headquarters, USAMEDCOM; or the AMEDD Center and School, FT Sam Houston. Functions not identified for transfer will be eliminated.

(3) The US Army Health Facility Planning Agency, a field operating agency of OTSG, will be redesignated as a subordinate activity within USAMEDCOM, pending further assessment of the proposal to establish the US Army Medical Materiel Command.

b. Fort Sam Houston, Texas.

(1) USAHSC will be inactivated.

(2) The USAMEDCOM will be activated, with TSG dual hatted as Commander. Headquarters, USAMEDCOM will be responsible for Armywide medical readiness and health care delivery, and the development and integration of doctrine, training, and materiel acquisition for the Army health service system.

(3) The US Army Dental Command (USADENCOM) will be

activated as a subordinate command within USAMEDCOM. Headquarters, USADENCOM will be responsible for Armywide dental readiness and dental care delivery.

(4) The US Army Veterinary Command (USAVETCOM) will be activated as a subordinate command within USAMEDCOM. Headquarters, USAVETCOM will be responsible for the veterinary triservice mission on a worldwide basis.

(5) The AMEDD Center and School will be realigned as a subordinate command within USAMEDCOM, and will receive the Graduate Medical Education and Graduate Dental Education mission from the US Army Health Professional Support Agency, Falls Church, Virginia.

c. FT Detrick, Maryland.

The US Army Medical Research and Development Command and the US Army Medical Materiel Agency will be reconfigured into the US Army Medical Materiel Command (USAMMC). These activities, currently OTSG ARSTAF field operating agencies, will be consolidated along with the US Army Health Facility Planning Agency, and redesignated as a major subordinate command of the USAMEDCOM. The USAMMC, with headquarters in FT Detrick, will have responsibility for the management of AMEDD research, development, acquisition, contracting, and logistics. A separate assessment will be submitted at a later date on how best to establish this command. Results of this assessment will be forwarded under separate cover.

d. Specific tangible improvements. Tangible improvements include the establishment of a single management framework, with TSG in command, which is responsible and accountable for the Army medical mission. This single organization, with its streamlined command structure and clear lines of authority, will be capable of effecting changes required for the transition of Army health care into a more business-like mode of operation. This will enable the AMEDD to assume its appropriate role in health care delivery to our beneficiaries as the nation continues to develop its framework for health care reform. It is also in line with recent DOD initiatives to centralize authority and responsibility for the military medical mission within the Assistant Secretary of Defense for Health Affairs (ASD (HA)), with decentralized implementation by the military departments. In addition, significant medical migration to FT Sam Houston will reduce AMEDD force structure requirements in the NCR.

e. Specific intangible improvements include enhanced medical planning, programming and budgeting within the AMEDD by placing responsibility for these functions under one commander; improved planning, coordination and integration on issues impacting on wartime readiness and peacetime health care; and

clarification of responsibility and accountability for missions and functions within USAMEDCOM.

f. Improvements will be verified by monitoring the management of a single, unified health management entity responsible and accountable for Armywide health care delivery, organization and doctrine, medical research, development, and acquisition, logistics management, preventive medicine and occupational health.

6. Major capabilities to be increased and/or decreased. The organizational realignment will result with internal mission transfers, resulting with an AMEDD which is more accessible, deployable and accountable in an era of Army restructuring and right sizing.

7. Major advantages and disadvantages.

a. Advantages.

(1) Organizes the AMEDD as the rest of the Army, with TSG in command of a single management framework responsible and accountable for the Army medical mission.

(2) Facilitates the transition of Army health care into a more business-like environment while managing programmed decrements and generating additional savings.

(3) Enhances planning, coordination, and integration of the Army-wide medical mission.

(4) Provides an effective response to ASD (HA) and national health care reform initiatives.

(5) Allows for migration from the NCR.

(6) Requires no additional resources from HQDA.

b. Disadvantages. Generates considerable, but manageable organizational turmoil during transition.

8. Summary changes and resources.

a. Pending resource requests. Not applicable.

b. Proponent resource changes (see enclosure 2).

c. Manpower (see enclosure 3).

d. AMHA functions and manpower (see enclosure 4).

e. Equipment (controlled items). There is no change in equipment requirements.

f. Funding requirements. None.

g. Facilities requirements. None.

9. Name of authority and method used to validate existing and added requirements. Chief, Health Care Manpower Programs and Analysis Division, Office of The Surgeon General. Manpower requirements were based on a functional assessment, and took into account programmed manpower decrements and the Five Year Medical Capability Plan.

10. Organizational, standardization and stabilization impact. This proposed realignment does not depart from any known organizational or standardization policy. Destabilization will be minimized through scheduled PCS reassignment for military personnel, and job placement for civilian employees, as required.

11. Readiness impact (MTOEs only). Medical readiness will be enhanced through enhanced TOE-TDA-Reserve Components integration.

12. UICs and names of parent units assessed in Concept Plan.

CSWOOLAA	Office of The Surgeon General
MDW47NAA	US Army Health Professional Support Agency
HSW3VYAA	HQS, US Army Health Services Command

13. Identification of thresholds, if any, in AR 10-5 that will be breached. On 4 October 1990, the SECARMY accepted a TSG proposal in concept to realign AMEDD command and control and approved the initiation of a formal realignment study under the provisions of AR 5-10. See enclosure 1 for additional background discussion.

14. Known or possible political sensitivities that should be made known to the Army staff. Establishment of a new medical command with worldwide responsibilities, inactivation of USAHSC and USAHPSA, and transfer of functions from the NCR to FT Sam Houston are issues known to have political sensitivity.

15. Identification of affected MDEPs, if any.

XMGH, XMGI, FASG, HSMT, HSPV, VPUB

16. Request Command of Assignment Code HS be assigned to the USAMEDCOM and that all UICs under Command of Assignment Code MD be transferred to HS, to depict realignment within USAMEDCOM.

17. Name, office symbol, and DSN number of the point of contact. COL Herbert A. Coley or Mr. Maurice Yaglom, Office of The Surgeon General (DASG-HCM), DSN 289-0305 or commercial (703) 756-0305.

18. List of supporting enclosures.

- a. Enclosure 1 - Background Information.
- b. Enclosure 2 - Proponent Resource Changes.
- c. Enclosure 3 - Manpower by Identity, Category, and AMS code.
- d. Enclosure 4 - AMHA Audit Trail.
- e. Enclosure 5 - Hard-copy Authorization Document

Background Discussion

On 29 January 1990, the Army announced its Quicksilver downsizing initiatives, which among other items included eliminating Headquarters USAHSC and transferring the peacetime patient care mission without resources to FORSCOM. Concerned with how this proposal would impact on an integrated, cost effective, and quality health care system, The Surgeon General (TSG) obtained DCSOPS concurrence and VCSA approval to submit an AMEDD counterproposal to the Quicksilver action and to apply the AMEDD share of the decrement to other AMEDD activities in order not to hinder patient care delivery.

TSG then directed his staff to review recommendations developed in the 1987 AMEDD Command and Control Study, which had been directed by the CSA to determine the most efficient and effective command and control structure for the AMEDD organizations and activities in CONUS. The major finding of this study was that TSG was recognized and held accountable as the overall manager of the AMEDD, but had limited command authority to effect change. The study recommended that TSG be designated as commander of a new MEDCOM collocated with the OTSG in the NCR, and that USAHSC be disestablished. The OTSG staff review determined the findings and recommendations of the 1987 study were still valid.

The TSG counterproposal to the Quicksilver recommendation emphasized centralizing accountability for health care delivery and reorganizing to provide the most efficient organization. On 27 August 1990, the VCSA approved this proposal, which then superseded the Quicksilver announcement as the preferred alternative.

On 4 October 1990, the Secretary of the Army (SECARMY) accepted TSG's proposal in concept and approved the initiation of a formal realignment study under the provisions of AR 5-10. At the time, the SECARMY expressed concern with establishing a medical command in the NCR, but indicated this would be a "yellow flag" due to the relatively low threshold of numbers migrating into the NCR. On 7 November 1990, the ASA(IL&E) directed that a realignment study under the provisions of AR 5-10 be conducted to assess three alternatives:

- (1) Status quo.
- (2) Elimination of Headquarters USAHSC in San Antonio, Texas, with transfer of responsibility of management of CONUS health care delivery to FORSCOM.
- (3) Elimination of Headquarters USAHSC, with TSG designated as Commander of a new medical command collocated in the NCR.

Based on an assessment by the Logistics Management Institute (LMI), the draft realignment study recommended collocation of a medical command with TSG in the NCR. Per the proposed realignment study, a net total of 308 military and civilian personnel would transfer into the NCR.

ENCL 1

However, sensitivity to migration into the NCR had greatly magnified since approval was originally provided to conduct the realignment study. It was determined this change in the political environment required exploration of a fourth alternative which would allow for assumption of command by TSG in the NCR without migration of spaces into the NCR. It would require reconfiguring the USAHPSA, a non-AMHA activity, into the Headquarters, USAMEDCOM, with AMHA spaces being identified from within the AMEDD as a trade off. It would also require leaving a health care delivery subordinate command in San Antonio. This review would include the identification of some functions and manpower spaces which could transfer from the NCR to San Antonio.

The ASA(IL&E) provided approval to study this alternative on 7 April 1992. This assessment was completed, with the recommendation that centralizing accountability by establishing the USAMEDCOM in the NCR, with TSG as Commander, is the most viable alternative. On 30 October 1992, TSG forwarded a memorandum through the Director of Management and the Director of the Army Staff, to the ASA(IL&E), stating his intent to conclude the AMEDD Realignment Study and submit a concept plan to the DCSOPS to obtain formal Army approval to realign AMEDD activities.

The concept plan for establishment of the USAMEDCOM was forwarded on 8 December 1992 for review by key Secretariat and ARSTAF offices. Although the majority of the staff concurred with TSG assuming command, concern was expressed with the proposed retention of USAHSC and the perception of "layering." Based on these comments and other on-going issues regarding proposals to reform the nation's health care system, TSG obtained approval from the VCSA to establish a special study group, Task Force Aesculapius, to reassess the original proposal depicted in the concept plan.

On 3 May 1993, TSG informed the DCSOPS by memorandum that a different alternative was being assessed by Task Force Aesculapius, which included inactivating USAHSC and activating the USAMEDCOM in FT Sam Houston, Texas. Subsequent presentation of the revised proposal to the Administrative Assistant to the Secretary of the Army, the Acting Assistant Secretary of the Army (Manpower and Reserve Affairs), and the Acting Secretary of the Army resulted with positive feedback.

On 8 July 1993, the Director of the Army Staff (DAS), along with ARSTAF principals, were formally apprised of AMEDD reorganization efforts. The DAS directed the concept plan be submitted to the ARSTAF for formal staffing and presented to the Secretary of the Army for decision by the end of July 1993.

PROPONENT RESOURCE CHANGES (REQUIREMENTS AND AUTHORIZATIONS)

Office of The Surgeon General
Headquarters, U.S. Army Health Professional Support Agency

	REQUIREMENTS			AUTHORIZATIONS		
	OFF	WO	ENL	WO	ENL	CIV
OTSG (CSWOOLAA)						
0195 TDA	62	0	1	59	122	61
CHANGES	-19	0	-1	-27	-47	-18
UIC TOTAL	56	0	0	46	102	56
USAHPA (MDW4N7AA)*						
0294 TDA	75	0	1	98	174	41
CHANGES	-75	0	-1	-98	-174	-41
UIC TOTAL	0	0	0	0	0	0

*WILL BE INACTIVATED

**U.S. ARMY MEDICAL COMMAND
PROPONENT RESOURCE CHANGES (REQUIREMENTS AND AUTHORIZATIONS)**

15 Jul 93

		REQUIREMENTS			AUTHORIZATIONS					
	OFF	WO	ENL	CIV	TOTAL	OFF	WO	ENL	CIV	TOTAL
HCSSA (HS-W398AA)										
Proposed 0195 TDA	64	1	48	347	460	30	1	40	257	328
Changes	-1			-16	-17	-1			-16	-17
UIC Total	63	1	48	331	443	29	1	40	241	311
HQ HSC (HS-W3VYAA)										
Proposed 0195 TDA	126	3	50	267	446	110	3	38	223	374
Changes	-126	-3	-50	-267	-446	-110	-3	-38	-223	-374
UIC Total	0	0	0	0	0	0	0	0	0	0
AMEDD Ctr & Sch (HS-W3VZAA)										
Proposed 0195 TDA	553	15	1329	1268	3165	433	12	1063	948	2456
Changes	-89		-5	-312	-406	-73		-4	-315	-392
UIC Total	464	15	1324	956	2759	360	12	1059	633	2064
MEDICAL COMMAND (XX-XXXXXAA)										
0195 TDA					0					0
Changes	109	1	27	274	411	108	1	27	271	407
UIC Total	109	1	27	274	411	108	1	27	271	407
DEN COM (XX-XXXXXAA)										
0195 TDA					0					0
Changes	5		2	5	12	5		2	5	12
UIC Total	5	0	2	5	12	5	0	2	5	12
VET COM (XX-XXXXXAA)										
0195 TDA					0					0
Changes	8	2	5	9	24	8	2	5	9	24
UIC Total	8	2	5	9	24	8	2	5	9	24

MANPOWER ALLOCATIONS BY CATEGORY, IDENTITY, AMSCD & MDEP FOR OFFICE OF THE SURGEON GENERAL, U.S. ARMY HEALTH PROFESSIONAL SUPPORT AGENCY

ALLOCATIONS FROM 0195 TDA										CHANGES (PLUS AND MINUS)										TOTALS ON PROPOSED CONCEPT PLAN									
AMSCD/MDEP	OFF	WO	ENL	GM	GS	TOTAL	OFF	WO	ENL	GM	GS	TOTAL	OFF	WO	ENL	GM	GS	TOTAL											
	61	0	1	10	49	121	-18	0	-1	-4	-23	-46	54	0	0	12	31		97										
952398/XMGH	0	0	0	0	0	0	+11	0	0	+3	+9	+23	0	0	0	0	0	0	0										
952398/XMGH	0	0	0	0	0	0	+2	0	0	+1	+1	+4	2	0	0	2	1	5											
952398/XMGH	61	0	1	10	49	121							56	0	0	14	32	102											
	0	0	0	0	3	3	0	0	0	0	-3	-3	0	0	0	0	0	0	0										
518991/FASG	41	0	0	11	52	104	-41	0	0	-11	-55	-107	0	0	0	0	0	0	0										
847714/FASG	41	0	0	11	55	107							0	0	0	0	0	0	0										

MANPOWER ALLOCATIONS BY CATEGORY, IDENTITY, AMSC, AND MDEP FOR THE NEW MEDICAL COMMAND

15 Jul 93 Revision

	AMS Code/MDEP	ALLOCATIONS PROGRAMMED FOR 0195 TDA							CHANGES (PLUS AND MINUS)							TOTALS ON PROPOSED CONCEPT PLAN						
		CIV							CIV							CIV						
		OFF	WO	ENL	GM	GS	WB	TOTAL	OFF	WO	ENL	GM	GS	WB	TOTAL	OFF	WO	ENL	GM	GS	WB	TOTAL
HCSSA (HS-U398AAA)	847714 HSHF	1				2		3							0	1				2		3
	847714 HSPV		1			25		26							0		1			25		26
	847714 MPTY	3		19		31		53							0	3		19		31		53
	847714 MSZ	26		21	16	181		244	-1				-16		-17	25		21	16	165		227
	847790 MUIM					2		2							0					2		2
	TDA TOTAL	30	1	40	16	241		328	-1				-16		-17	29	1	40	16	225		311
HQ NSC (HS-U3VYAAA)	847798 VPUB				1	1		2				-1	-1		-2							0
	847798 XNGH	107	3	36	22	192		360	-107	-3	-36	-22	-192		-360							0
	847798 XNGI	3		2		9		14	-3		-2		-9		-14							0
	TDA TOTAL	110	3	38	23	202		376	-110	-3	-38	-23	-202		-376	0	0	0	0	0		0
AMEDD Ctr & Sch (HS-U3VZAAA)	121018 VTRD	45	1	4	1	38		89								45	1	4	1	38		89
	442002 JDFH					2		2												2		2
	518991 ARFT	3				64		67	-3				-57		-60					7		7
	814771 DMTB					1		1												1		1
	846761 HSMT	325	11	1042	1	524	11	1914	-12				-40		-52	313	11	1042	1	484	11	1862
	847714 HSAT					1		1											1			1
	847714 HSHE					1		1											1			1
	847714 HSPV	58		5	11	209		283	-58		-4	-11	-203		-276			1		6		7
	847714 MSZ	2		4		48		54					-4		-4	2		4		44		50
	847790 MUIM			8	1	22	9	40										8	1	22	9	40
	878789 VCND					4		4												4		4
	TDA TOTAL	433	12	1063	14	914	20	2456	-73		-4	-11	-304		-392	360	12	1059	3	610	20	2064
MED CMD (XX-XXXXAAA)	847798 VPUB							0					2		2					2		2
	847798 XNGH							0	105	1	27	33	227		393	105	1	27	33	227		393
	847798 XNGI							0	3			1	8		12	3			1	8		12
	TDA TOTAL	0	0	0	0	0		0	108	1	27	34	237		407	108	1	27	34	237		407
DEN COM (XX-XXXXAAA)	847715 HSDC							0	5		2		5		12	5		2		5		12
VET COM (XX-XXXXAAA)	847714 HSPV							0	8	2	5		9		24	8	2	5		9		24

MANPOWER ALLOCATIONS BY CATEGORY, IDENTITY, AMSC, AND MDEP FOR THE NEW MEDICAL COMMAND

15 Jul 93 Revision

		ALLOCATIONS PROGRAMMED FOR 0195 TDA							CHANGES (PLUS AND MINUS)							TOTALS ON PROPOSED CONCEPT PLAN						
		CIV							CIV							CIV						
AMS Code/MDEP		OFF	WO	ENL	GM	GS	WB	TOTAL	OFF	WO	ENL	GM	GS	WB	TOTAL	OFF	WO	ENL	GM	GS	WB	TOTAL
RECAP	121018 VTRD	45	1	4	1	38		89								45	1	4	1	38		89
	442002 JDFM				2			2												2		2
	518991 ARFT	3			64			67	-3				-57		-60					7		7
	814771 DMTB				1			1												1		1
	846761 HSMT	325	11	1042	1	524	11	1914	-12				-40		-52	313	11	1042	1	484	11	1862
	847714 HSAT				1			1												1		1
	847714 HSHE				1			1												1		1
	847714 HSHF	1			2			3								1				2		3
	847714 HSPV	58	1	5	11	234		309	-50	2	1	-11	-194		-252	8	3	6		40		57
	847714 MPTT	3		19	31			53					-20		-21	3		19		31		53
	847714 MSZ	28		25	16	229		298	-1				5		12	27		25	16	209		277
	847715 HSDC							0	5	2						5		2		5		12
	847790 MUJH			8	1	24	9	42									8		1	24	9	42
	847798 VPUB				1	1		2				-1	1							2		2
	847798 XMGH	107	3	36	22	192		360	-2	-2	-9	11	35		33	105	1	27	33	227		393
	847798 XMGI	3		2		9		14			-2	1	-1		-2	3			1	8		12
	878789 VCWD				4			4												4		4
TOTAL		573	16	1141	53	1357	20	3160	-63	-8	0	-271			-342	510	16	1133	53	1086	20	2818

NOTE: HCSSA is included because the HQ HSC DCSRM Finance and Accounting Division is now documented on the HCSSA TDA but will become part of the new MEDCOM TDA.

AMHA AUDIT TRAIL FORMAT

LOSING ORGANIZATION		GAINING ORGANIZATION		MILITARY AUTH		CIVILIAN AUTH		AGGREGAT AUT									
MDEP	RCOND	UIC	AMSCO	/MDEP	RCOND	UIC	AMSCO	/	OFF	WO	ENL	TMIL	/	C-AUTH	C-TYPE	/	
XMGGH	06	WO3JAA	665898	/	XMGGH	XX	XXXXXXX	847798	/	108	1	27	136	/	271	101	4

UICs:
 WO3JAA - HQs US ARMY MEDICAL RESEARCH DEVELOPMENT COMMAND
 XXXXXX - HQs US ARMY MEDICAL COMMAND

NOTE: Coordination will be effected with the Assistant Secretary of the Army (Manpower and Reserve Aff-irs) and the Office of the Administrative Assistant to the Secretary of the Army to re-designate WO3JAA as non-AMHA. The only AMHA activity within the USAMEDCOM will be the Headquarters. If approved total number of spaces currently designated as AMHA will be reduced from 505 to 402.

HARD COPY AUTHORIZATION DOCUMENTS

ENCL 5

TDA CSWOOLAA
CCNUM CS0196
EDATE

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL

SECTION I

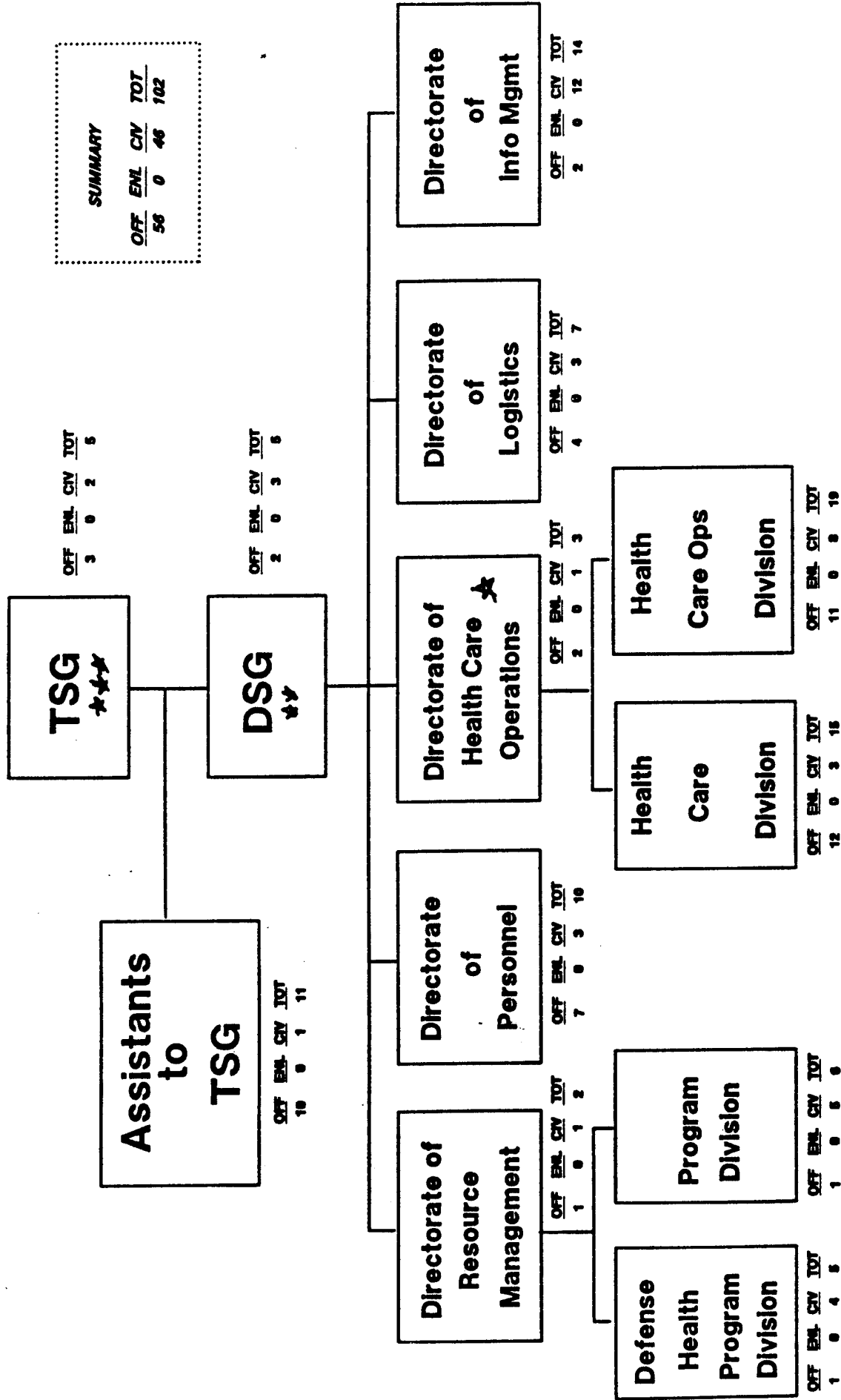
1. CHANGES TO : TDANUM CSWOOLAA, CCNUM CS0195
2. LOCATION: FALLS CHURCH, VA 22041-3258
3. ASSIGNMENT: HQDA
4. MISSION: THE OFFICE OF THE SURGEON GENERAL IS RESPONSIBLE FOR ADVISING AND ASSISTING THE SECRETARY OF THE ARMY, AND THE CHIEF OF STAFF, ARMY, AND OTHER PRINCIPALS ON ALL MATTERS PERTAINING TO THE MILITARY HEALTH SERVICE SYSTEM. REPRESENTS THE ARMY TO THE EXECUTIVE BRANCH, CONGRESS, DOD AGENCIES AND OTHER ORGANIZATIONS ON ALL HEALTH POLICIES AFFECTING THE ARMY MEDICAL DEPARTMENT.
5. CAPABILITIES: WORKLOADS. AVERAGE POPULATION:

MILITARY:	56
DA CIVILIAN:	46
TOTAL	102
6. AUTHORIZATION STATEMENT: THIS TABLE IS IN ACCORDANCE WITH ARs 5-10 AND 10-32.

SECTION I.....

DEPARTMENT OF THE ARMY

OFFICE OF THE SURGEON GENERAL (PROPOSED)



MYWORKS64PROP3.DRW
DASG-HCM

REQUIREMENTS-AUTHORIZATIONS

PROPOSED OTSG ARSTAF TDA - 9 JULY 1993

PARA LINE	DESCRIPTION	MDEP	GR	MOS	BR	ID	AMS	REQ	AUTH	REMARKS	STRENGTH
001	OFC OF TSG										
001	TSG	XMGH	LG	00B00	GO	K	952398YOBBBC	1	1	TS	
001	EXEC OFF	XMGH	06	70A67	MS	K	952398YOBBBC	1	1	TS	
001	ASST EXEC OFF	XMGH	05	70A67	MS	K	952398YOBBBC	1	1	TA	
001	SECY (STENO)	XMGH	10	00318	GS	C	952398YOBBBC	1	1	TX	
001	SACO	XMGH	09	00301	GS	C	952398YOBBBC	1	1	TX	
	PARAGRAPH TOTAL							5	5		
002	OFC OF ASSTS TO TSG										
002	MC ASST TO TSG	XMGH	06	60A00	MC	K	952398YOBBBC	1	1	TA	
002	DC ASST TO TSG	XMGH	06	63R00	DE	K	952398YOBBBC	1	1	TA	
002	VC ASST TO TSG	XMGH	06	64A00	VC	K	952398YOBBBC	1	1	TA	
002	SP ASST TO TSG	XMGH	06	65A00	SP	K	952398YOBBBC	1	1	TA	
002	AN ASST TO TSG	XMGH	06	66A00	AN	K	952398YOBBBC	1	1	TA	
002	MS ASST TO TSG	XMGH	06	70A67	MS	K	952398YOBBBC	1	1	TA	
002	DC STAFF OFF	XMGH	05	63R00	DE	K	952398YOBBBC	1	1	TA	
002	VET STAFF OFF	XMGH	05	75A64	VC	K	952398YOBBBC	2	2	TA	
002	AN STAFF OFF	XMGH	05	66A00	AN	K	952398YOBBBC	1	1	TA	
002	SECY (STENO)	XMGH	08	00318	GS	C	952398YOBBBC	1	1	TX	
	PARAGRAPH TOTAL							11	11		
003	OFC OF DSG										
003	DSG	XMGH	MG	00B00	GO	K	952398YOBBBC	1	1	TS	
003	STRATEGIC MARK	XMGH	15	01035	GM	C	952398YOBBBC	1	1	TA	
003	CONG LIAISON	XMGH	05	70C67	MS	K	952398YOBBBC	1	1	TA	
003	SECY (STENO)	XMGH	09	00318	GS	C	952398YOBBBC	1	1	TX	
003	SECY (STENO)	XMGH	07	00318	GS	C	952398YOBBBC	1	1	TX	
	PARAGRAPH TOTAL							5	5		

PARA LINE	DESCRIPTION	MDEP	GR	MOS	BR	ID	AMS	STRENGTH REQ AUTH	REMARKS
004 00	DIR HCOPS								
004 01	DIRECTOR	XMGH	BG	00B00	GO	K	952398Y0XZZ	1 1	TS
004 02	OPNS STF OFF	XMGH	06	70H67	MS	K	952398Y0XZZ	1 1	TA
004 03	SECY (STENO)	XMGH	08	00318	GS	C	952398Y0XZZ	1 1	TX
PARAGRAPH TOTAL									3 3
004A 00	HEALTHCARE DIV								
004A 01	CHIEF	XMGH	06	60A00	MC	K	952398Y0BBC	1 1	TS
004A 02	QA STF OFF	XMGH	06	60A00	MC	K	952398Y0BBC	1 1	TA
004A 03	EFMP STF OFF	XMGH	06	60A00	MC	K	952398Y0BBC	1 1	TA
004A 04	PREV MED STF OFF	XMGH	06	60C00	MC	K	952398Y0BBC	1 1	TA
004A 05	MEN HLTH STF OFF	XMGH	06	60W00	MC	K	952398Y0BBC	1 1	TA
004A 06	PRIM CARE STF OFF	XMGH	06	61H00	MC	K	952398Y0BBC	1 1	TA
004A 07	TERT CARE STF OFF	XMGH	06	61J00	MC	K	952398Y0BBC	1 1	TA
004A 08	FIT/WEILL STF OFF	XMGH	06	65A00	SP	K	952398Y0BBC	1 1	TA
004A 09	NUT CARE STF OFF	XMGH	06	65C00	SP	K	952398Y0BBC	1 1	TA
004A 10	PAD STF OFF	XMGH	06	70E67	MS	K	952398Y0BBC	1 1	TA
004A 11	ALL SCI STF OFF	XMGH	06	71E67	MS	K	952398Y0BBC	1 1	TA
004A 12	ENV HLTH STF OFF	XMGH	06	72D67	MS	K	952398Y0BBC	1 1	TA
004A 13	MED STDS STF OFF	XMGH	14	00601	GM	C	952398Y0BBC	1 1	TA
004A 14	SECY (STENO)	XMGH	07	00318	GS	C	952398Y0BBC	1 1	TX
004A 15	SECY (OA)	XMGH	06	00318	GS	C	952398Y0BBC	1 1	TX
PARAGRAPH TOTAL									15 15
004B 00	HLTH CARE OPNS DIV								
004B 01	CHIEF	XMGH	06	70H67	MS	K	952398Y0XZZ	1 1	TS
004B 02	SECY (OA)	XMGH	07	00318	GS	C	952398Y0XZZ	1 1	TX
SUBTOTAL									2 2

PARA LINE	DESCRIPTION	MDEP	GR	MOS	BR	ID	AMS	REQ	STRENGTH	REMARKS	AUDIT
									AUTH	TRAIL	
004B 03	PLANS & OPNS BR										
004B 04	CHIEF	XMGH	06	70H67	MS	K	952398YOXZZ	1	1	TS	A
004B 05	USAR OPNS STF OFF	XMGH	05	70H67	MS	K	4H101100BAE	1	1	TA92	A
004B 06	READ OFF	XMGH	05	70H67	MS	K	952398YOXZZ	1	1	TA	A
004B 07	CHEM BIO STF OFF	XMGH	05	72A67	MS	K	952398YOXZZ	1	1	TA	A
004B 08	OI (ODCSOPS)	XMGH	05	70H67	MS	K	952398YOXZZ	1	1	TA	A
004B 09	PLANS OFF	XMGH	04	70H67	MS	K	952398YOXZZ	2	2	TA	A
004B 10	OPNS STF OFF	XMGH	04	70H67	MS	K	952398YOXZZ	2	2	TA	A
004B 11	ARNG OPNS STF OFF	XMGH	04	70H67	MS	K	2H101100BAE	1	1	TA89	A
004B 12	SECURITY ASST	XMGH	12	00345	GS	C	952398YOXZZ	1	1	TA	A
004B 13	MGT ANAL	XMGH	12	00343	GS	C	952398YOXZZ	1	1	TA	A
004B 14	SYS INTEGRATOR	XMGH	12	00345	GS	C	952398YOXZZ	1	1	TA	A
004B 15	SECY (OA)	XMGH	06	00318	GS	C	952398YOXZZ	1	1	TX	A
	SUBTOTAL							12	12		
004B 16	MANPOWER PROG & ANAL BR										
004B 17	CHIEF	XMGH	14	00343	GM	C	952398YOXMD	1	1	TS	A
004B 18	MPR CONTROL OFF	XMGH	05	70H67	MS	K	952398YOXMD	1	1	TA	A
004B 19	MPR CONTROL OFF	XMGH	05	70C67	MS	K	952398YOXMD	1	1	TA	A
	MGT ANAL	XMGH	11	00343	GS	C	952398YOXMD	1	1	TA	A
	SECY (OA)	XMGH	06	00318	GS	C	952398YOXMD	1	1	TX	A
	SUBTOTAL							5	5		
	PARAGRAPH TOTAL							19	19		
005 00	DIR LOGISTICS										
005 01	DIRECTOR	XMGH	06	70K67	MS	K	952398YONNZ	1	1	TS	A
005 02	LOG STF OFF	XMGH	05	70K67	MS	K	952398YONNZ	3	3	TA	A
005 03	LOG MGT SPEC	XMGH	14	00346	GM	C	952398YONNZ	1	1	TA	A
005 04	LOG MGT SPEC	XMGH	13	00346	GM	C	952398YONNZ	1	1	TA	A
005 05	SECY	XMGH	08	00318	GS	C	952398YONNZ	1	1	TX	A
	PARAGRAPH TOTAL							7	7		

PARA LINE	DESCRIPTION	MDEP	GR	MOS	BR	ID	AMS	STRENGTH REQ AUTH	REMARKS
006 00	DIR RESOURCE MGT								
006 01	DIRECTOR	XMGH	06	70C67	MS	K	952398YOBBC	1 1	TS
006 02	SECY	XMGH	08	00318	GS	C	952398YOBBC	1 1	TX
	PARAGRAPH TOTAL							2 2	
006A 00	PROG DIV								
006A 01	CHIEF	XMGH	15	00345	GM	C	952398YOFGA	1 1	TS
006A 02	PROG ANAL	XMGH	05	70C67	MS	K	952398YOFGA	1 1	TA
006A 03	PROG ANAL	XMGH	14	00345	GM	C	952398YOFGA	2 2	TA
006A 04	OPNS RSCH ANAL	XMGH	12	01515	GS	C	952398YOFGA	1 1	TA
006A 05	SECY (OA)	XMGH	07	00318	GS	C	952398YOFGA	1 1	TX
	PARAGRAPH TOTAL							6 6	
006B 00	DEF HLTH PROG BUDGET								
006B 01	CHIEF	XMGH	05	70C67	MS	K	952398YOFGA	1 1	TS
006B 02	SR BUD ANAL	XMGH	14	00560	GM	C	952398YOFGA	1 1	TA
006B 03	BUD ANAL	XMGH	13	00560	GS	C	952398YOFGA	1 1	TA
006B 04	BUD ANAL	XMGH	12	00560	GS	C	952398YOFGA	2 2	TA
	PARAGRAPH TOTAL							5 5	
007 00	DIR PERS POL								
007 01	DIRECTOR	XMGH	06	70F67	MS	K	952398YORKA	1 1	TS
007 02	PERSO (ODCSPER)	XMGH	05	70F67	MS	K	952398YORKA	1 1	TA
007 03	PERS POL OFF	XMGH	05	70F67	MS	K	952398YORKA	5 5	TA
007 04	USAR PER STF QFF	XMGH	05	70F67	MS	K	4H101100RKA	1 1	TA 92
007 05	CIV PERS MGT SP	XMGH	13	00201	GM	C	952398YORKA	1 1	TA
007 06	MIL PERS MGT	XMGH	13	00205	GM	C	952398YORKA	1 1	TA
007 07	SECY	XMGH	08	00318	GS	C	952398YORKA	1 1	TX
	PARAGRAPH TOTAL							10 10	

PARA LINE	DESCRIPTION	MDEP	GR	MOS	BR	ID	AMS	STRENGTH REQ AUTH	REMARKS
008 00	DIR INFO MGMT								
008 01	DIRECTOR	XMGI	06	70D67	MS	K	952398YOXZZ	1 1	TS
008 02	INFO MGMT OFF	XMGI	05	70D67	MS	K	952398YOXZZ	1 1	TA
008 03	COMP SPEC	XMGI	13	00334	GM	C	952398YOXZZ	2 2	TX
008 04	SECY (OA)	XMGI	06	00318	GS	C	952398YOXZZ	1 1	TX
	SUBTOTAL							5 5	
	ADMIN SERVICES								
008 05	SPT SVCS SPV	XMGH	13	00342	GM	C	952398YOAAC	1 1	TS
008 06	EDIT/PRINT MEDIA	XMGH	11	01082	GS	C	952398YOAAC	1 1	TA
008 07	GEN SUP SPEC	XMGH	11	02001	GS	C	952398YOAAC	1 1	TA
008 08	MGMT ANAL (RCDS)	XMGH	11	00343	GS	C	952398YOAAC	1 1	TA
008 09	SECY (OA)	XMGH	08	00318	GS	C	952398YOAAC	1 1	TX
008 10	MIL PER TECH	XMGH	07	00204	GS	C	952398YOAAC	1 1	TX
008 11	CIV PER TECH	XMGH	07	00204	GS	C	952398YOAAC	1 1	TX
008 12	MAIL CLK	XMGH	04	00305	GS	C	952398YOAAC	2 2	TX
	SUBTOTAL							9 9	
	PARAGRAPH TOTAL							14 14	
	TDA TOTAL							102 102	

TDA HSXXXXXX
CCNUM HS0295
EDATE

HEADQUARTERS
US ARMY MEDICAL COMMAND

SECTION I

1. CHANGES TO :

A. ACTIVATION: ACTIVATE US ARMY MEDICAL COMMAND, FORT SAM
HOUSTON, TEXAS

B. MODIFICATION:

C. RESCISSIONS: INACTIVATE HEADQUARTERS, US ARMY HEALTH
SERVICES COMMAND.

D. SUPERSESIONS:

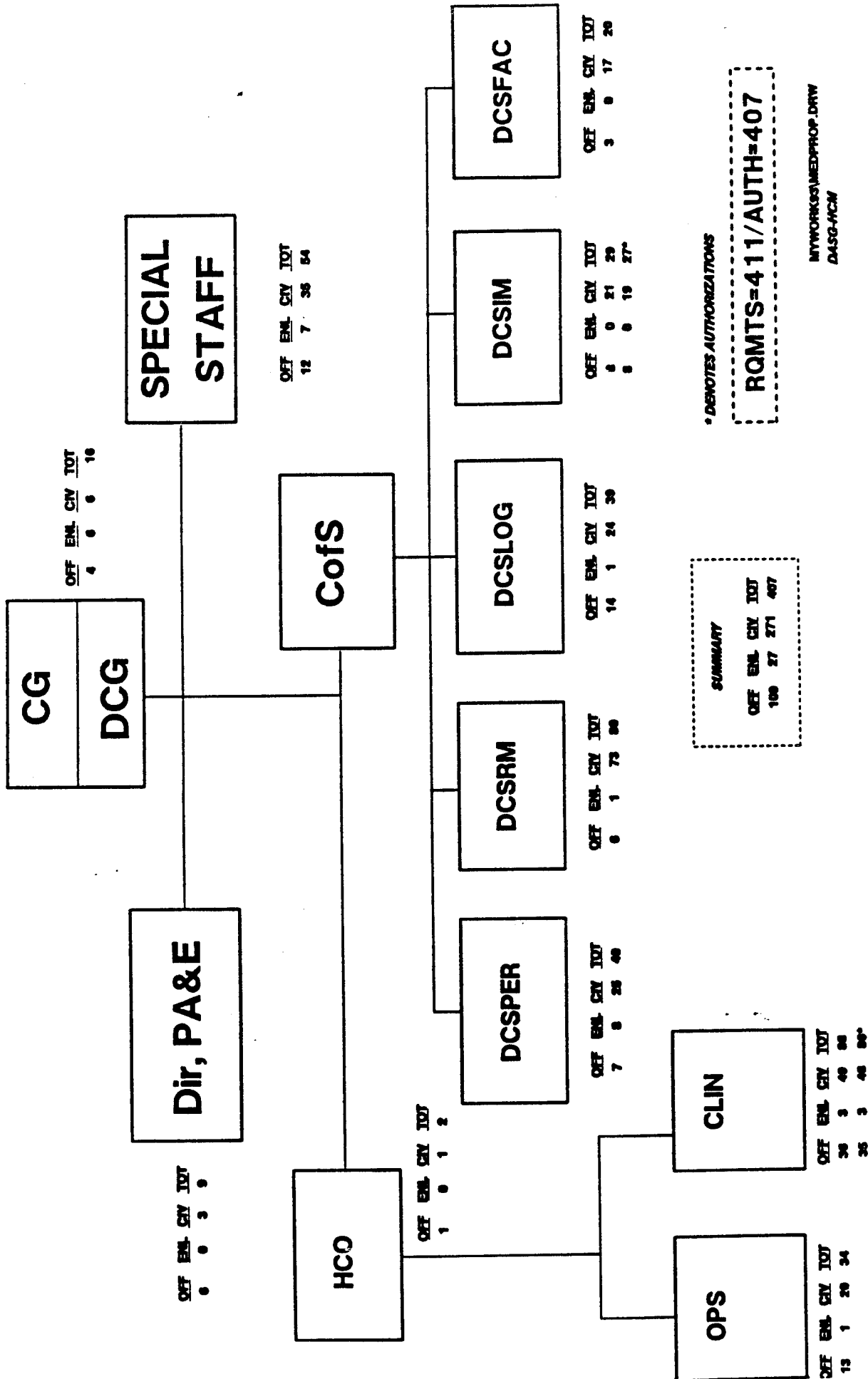
SECTION I.....

PREP. 920917 TDA HSXXXXXX
UNCLASSIFIED

HQS, US ARMY MEDICAL COMMAND
FORT SAM HOUSTON, TEXAS

PROPOSED ORGANIZATION

HQ, U.S. ARMY MEDICAL COMMAND



2. LOCATION: FORT SAM HOUSTON, TEXAS 78234

3. ASSIGNMENT: US ARMY MEDICAL COMMAND

4. DATE OF LAST SURVEY

A. MANPOWER: NA

B. EQUIPMENT: NA

5. MISSION: THE HEADQUARTERS, US ARMY MEDICAL COMMAND, A MAJOR ARMY COMMAND OF THE DEPARTMENT OF THE ARMY, HAS RESPONSIBILITY FOR:

A. COMMAND AND CONTROL OF WORLDWIDE ARMY HEALTH SERVICE SYSTEM.

B. PROVISION OF DIRECTION AND LONG RANGE PLANNING FOR THE ARMY MEDICAL DEPARTMENT.

C. DEVELOPMENT AND INTEGRATION OF DOCTRINE, TRAINING, LEADER DEVELOPMENT, ORGANIZATION, AND MATERIEL FOR THE ARMY HEALTH SERVICE SYSTEM.

D. PROGRAMMING, BUDGETING AND ALLOCATION OF RESOURCES FOR THE OPERATION OF USAMEDCOM ORGANIZATIONS AND ACTIVITIES.

LAST PAGE OF SECTION 1

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[illegible]

004B 00	MWR OFC	13	00340	GM	C	84779810	RFA	XMGH	1	1	
004B 01	MWR PM										
004B 02	COM & FAM SPT SP	12	01701	GS	C	84779810	RFA	XMGH	1	1	
004B 03	FIN OPNS ASST	07	00503	GS	C	84779810	RFA	XMGH	1	1	
SUBTOTAL										3	3
004C 00	MIL PERS DIV										
004C 01	C MIL PER DIV	05	70F67	MS	K	84779810	PBA	XMGH	1	1	
004C 02	OA ASST	06	00326	GS	C	84779810	PBA	XMGH	1	1	
SUBTOTAL										2	2
004D 00	PERS/OPNS BR										
004D 01	C PER/OPN BR	05	70F67	MS	K	84779810	PBD	XMGH	1	1	
004D 02	PERS STF OFF-RC (92)	04	70F67	MS	K	84779810	PBC	XMGH	1	1 NON-ADD	
004D 03	PER SGT	E7	75Z40	NC	I	84779810	PBD	XMGH	1	1	
004D 04	PERS STF NCO-RC (92)	E7	75Z40	NC	I	84779810	PBC	XMGH	1	1 NON-ADD	
004D 05	MILPER MGT SP	09	00205	GS	C	84779810	PBD	XMGH	1	1	
004D 06	MIL PERS TECH	07	00204	GS	C	84779810	PBD	XMGH	1	1	
004D 07	MIL PER CLK (OA)	04	00204	GS	C	84779810	PBD	XMGH	1	1	
004D 08	SECY (OA)	04	00318	GS	C	84779810	PBD	XMGH	1	1	
SUBTOTAL										6	6
004E 00	PERS MGT BR										
004E 01	C PERS MGT BR	05	70F67	MS	K	84779810	PAC	XMGH	1	1	
004E 02	MS PER OFF	04	70F67	MS	K	84779810	PBD	XMGH	1	1	
004E 03	PER MGT SUPV	E8	75Z50	NC	I	84779810	PAC	XMGH	1	1	
004E 04	PER MGT SUPV	E6	75C30	NC	I	84779810	PAC	XMGH	1	1	
004E 05	PER MGT SP	E4	75C10	NC	I	84779810	PAC	XMGH	1	1	
004E 06	M-P CLK (OA)	05	00204	GS	C	84779810	PAC	XMGH	1	1	
004E 07	M-P CLK (OA)	04	00204	GS	C	84779810	PAC	XMGH	1	1	
004E 08	SECY (OA)	04	00318	GS	C	84779810	PAC	XMGH	1	1	
SUBTOTAL										8	8

004F	00	PERS ACT BR	04	70F67	MS	K	84779810	PTC	XMGH	1	1
004F	01	C PERS ACT BR			NC	I	84779810	PTC	XMGH	1	1
004F	02	PER ACT SP	E8	75250	GS	C	84779810	PTC	XMGH	1	1
004F	03	M-P REL	07	00204	GS	C	84779810	PTC	XMGH	1	1
004F	04	MIL PER TECH	07	00204	GS	C	84779810	PTC	XMGH	1	1
004F	05	M-P CLK (QA)	05	00204	GS	C	84779810	PTC	XMGH	3	3
004F	06	SECY (QA)	05	00318	GS	C	84779810	PTC	XMGH	1	1
SUBTOTAL											
8											
WITH DUTY NCR											
004G	00	SPECIAL PAY BR			MS	K	84779810	P8D	XMGH	1	1
004G	01	CHIEF	04	70F67	GS	C	84779810	P8D	XMGH	1	1
004G	02	MIL PER CLK (QA)	07	00204	GS	C	84779810	P8D	XMGH	2	2
004G	03	MIL PER CLK (QA)	06	00204	GS	C	84779810	P8D	XMGH	2	2
SUBTOTAL											
4											
004H	00	REENLIST BR			NC	I	84779810	PUV	XMGH	1	1
004H	01	C REENL BR	E9	00R50	NC	I	84779810	PUV	XMGH	1	1
004H	02	RETENT NCO	E7	00R40	NC	I	84779810	PUV	XMGH	2	2
SUBTOTAL											
2											
TOTAL											
40											
005	00	DCSIM			MS	K	84779810	DNG	XMGH	1	1
005	01	DCSIM	06	70067	GS	C	84779810	DAZ	XMGH	1	1
005	02	PLN/RESOURCE MGR	13	00560	GS	C	84779810	DNG	XMGH	1	1
005	03	SECY (STENO)	06	00318	GS	C	84779810	DAZ	XMGH	1	1
005	04	QA CLERK	03	00326	GS	C	84779810	DAZ	XMGH	1	1
SUBTOTAL											
4											

006J	00	EQUIP BR	05	70K67	MS	K	84779810	NMC	XMGH	1	1	
006J	01	C EQUIP BR	05	70K67	MS	K	84779810	NMC	XMGH	1	1	
006J	02	SUP MGT REP	11	02003	GS	C	84779810	NMC	XMGH	1	1	
006J	03	INV MGT SP	11	02010	GS	C	84779810	NMC	XMGH	1	1	
SUBTOTAL											3	3
006K	00	READINESS AND MOB DIV										
006K	01	C READ AND MOB DIV	05	70K67	MS	K	84779810	KCY	XMGH	1	1	
006K	02	SECY (OA)	05	00318	GS	C	84779810	KCY	XMGH	1	1	
SUBTOTAL											2	2
006L	00	CONTINGENCY REQ BR										
006L	01	CHIEF	05	70K67	MS	K	84779810	KCY	XMGH	1	1	
006L	02	LOG MGT SP	12	00346	GS	C	84779810	KCY	XMGH	1	1	
SUBTOTAL											2	2
006M	00	FORCE INTEG & TRNG OFC										
006M	01	CHIEF	05	70K67	MS	K	84779810	KCY	XMGH	1	1	
006M	02	LOG MGT SP	12	00346	GS	C	84779810	KCY	XMGH	3	3	
SUBTOTAL											4	4
006N	00	GLOBAL LIAISON BR										
006N	01	CHIEF	05	70K67	MS	K	84779810	KCY	XMGH	1	1	
006N	02	LOG MGT SP	12	00346	GS	C	84779810	KCY	XMGH	1	1	
SUBTOTAL											2	2
006P	00	TRANS & INTRAM VIS BR										
006P	01	LOG MGT SP	13	02130	GM	C	84779810	NMF	XMGH	1	1	
SUBTOTAL											1	1
TOTAL											39	39
007	00	DCS FACILITIES										
007	01	DCSFAC	06	70K67	MS	K	84779810	JDF	XMGH	1	1	
SUBTOTAL											1	1

010A	00	OFC SR RC ADV									
010A	01	SR ARNG ADV (89)	06	70H67	MS	K	84779810	RJA	XMGH		1 NON-ADD
010A	02	SR USAR ADV (92)	06	70H67	MS	K	84779810	RJA	XMGH		1 NON-ADD
010A	03	OPS/TNG STF OFF-RC (92)	05	70H67	MS	K	84779810	RJA	XMGH		1 NON-ADD
010A	04	SR MED NCO-RC (92)	E9	91B50	NC	I	84779810	RJA	XMGH		1 NON-ADD

SUBTOTAL		0
		0

0108	00	OPERATIONS DIV				
0108	01	CHIEF	06	70H67	MS	K 84779810 XBA XMGH 1 1
0108	02	SECY (OA)	05	00318	GS	C 84779810 XBA XMGH 1 1

SUBTOTAL	2	2
TOTAL	2	2

010C	00	MSN/REALIGN BR								
010C	01	C MSN/RELG BR	05	67A00	MS	K	84779810	XMG	XMGH	1
010C	02	HLTH CARE SYS PLNR	04	70A67	MS	K	84779810	XMG	XMGH	2
010C	03	HLTH SYS SP	12	00671	GS	C	84779810	XMG	XMGH	1
010C	04	SECY (OA)	05	00318	GS	C	84779810	XMG	XMGH	1

SUM TOTAL	5	5
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	0100	00	SCTY & INTEL BR				
	0100	01	SCTY SP	13	00080	GS C	84779810 IRA XMGH 1
	0100	02	SCTY ASST	07	00086	GS C	84779810 IRA XMGH 1
	0100	03	SECY (QA)	04	00318	GS C	84779810 IRA XMGH 1

TOTAL

[illegible]

99
SUBTOTAL

010F	00	TNG BR	05	70H67	MS	K	84779810	CBA	XMGH	1	1
010F	01	C TNG			MC	I	84779810	CBA	XMGH	1	1
010F	02	TNG NCO	E7	01B40	GS	C	84779810	CBA	XMGH	1	1
010F	03	HLTH SYS SP	11	00301						3	3
SUBTOTAL											
010G	00	READINESS/PLN BR	14	00301	GM	C	84779810	YAX	XMGH	1	1
010G	01	SUPV NIL PLN SP	05	70H67	MS	K	84779810	YAX	XMGH	1	1
010G	02	MOB PLANNER	05	70H67	MS	K	84779810	YAX	XMGH	1	1
010G	03	MOB PLANNER-RC (92)	05	70H67	MS	K	84779810	YAX	XMGH	1	1
010G	04	NG PLANNER (89)	05	70H67	MS	K	84779810	YAX	XMGH	1	1
010G	05	PLANS & TNG OFF	04	70H67	MS	K	84779810	YAX	XMGH	1	1
010G	06	HLTH SYS SP	12	00671	GS	C	84779810	YAX	XMGH	1	1
010G	07	SECY (QA)	04	00318	GS	C	84779810	YAX	XMGH	1	1
SUBTOTAL											
010H	00	STRAT/BUSINESS PLAN BR	06	67A00	MS	K	84779810	XLY	XMGH	1	1
010H	01	CHIEF	14	00301	GS	C	84779810	XLY	XMGH	1	1
010H	02	PLANS OFF	13	00301	GS	C	84779810	XLY	XMGH	1	1
010H	03	PLANS OFF	12	00343	GS	C	84779810	XLY	XMGH	3	3
010H	04	MGT ANAL	05	00318	GS	C	84779810	XLY	XMGH	1	1
010H	05	SECY (QA)								7	7
SUBTOTAL											
010I	00	CLINICAL OPNS DIV	06	60A00	MC	K	84779810	HWZ	XMGH	1	1
010I	01	CHIEF CLIN OPNS	E9	91C50	MC	I	84779810	HWZ	XMGH	1	1
010I	02	SR ENL ADV	06	00318	GS	C	84779810	HWZ	XMGH	1	1
010I	03	SECY (STENO)								3	3
SUBTOTAL											

RESOURCE UTIL/ANAL DIV

010P 00	14	00343	GM	C	84779810	OBC	XMGH	1	1
010P 01	13	00343	GM	C	84779810	OBC	XMGH	2	2
010P 02	12	00343	GS	C	84779810	OBC	XMGH	6	6
010P 03	12	01510	GS	C	84779810	OBC	XMGH	1	1
010P 04	11	00343	GS	C	84779810	OBC	XMGH	2	2
010P 05	05	00318	GS	C	84779810	OBC	XMGH	1	1

SUBTOTAL

13 13

PROGRAM BR

010Q 00	04	67E00	MS	K	84779810	HWZ	XMGH	1	1
010Q 01	12	00560	GS	C	84779810	HWZ	XMGH	1	1
010Q 02	11	00343	GS	C	84779810	HWZ	XMGH	1	1
010Q 03	11	00671	GS	C	84779810	HWZ	XMGH	1	1
010Q 04	09	00671	GS	C	84779810	HWZ	XMGH	1	1
010Q 05	04	00318	GS	C	84779810	HWZ	XMGH	1	1

SUBTOTAL

6 6

RESOURCE ANAL BR

010R 00	13	01530	GM	C	84779810	FGE	XMGH	1	1
010R 01	13	01530	GM	C	84779810	FGE	XMGH	1	1
010R 02	04	01531	GS	C	84779810	FGE	XMGH	1	1

SUBTOTAL

3 3

PATIENT ADMIN BRANCH

010S 00	06	70E67	MS	K	84779810	HWZ	XMGH	1	1
010S 01	05	70E67	MS	K	84779810	HWZ	XMGH	1	1
010S 02	04	70E67	MS	K	84779810	HWZ	XMGH	1	1
010S 03	E8	71G50	NC	I	84779810	HWZ	XMGH	1	1
010S 04	12	00301	GS	C	84779810	HWZ	XMGH	1	1
010S 05	12	00671	GS	C	84779810	HWZ	XMGH	1	1
010S 06	11	00671	GS	C	84779810	HWZ	XMGH	1	1
010S 07	05	00318	GS	C	84779810	HWZ	XMGH	1	1

SUBTOTAL

8 8

010T 00 CLAIMS CONSULTATION BR

010T	01	CHIEF/ATTY	05	60A00	MC	84779810	BCB	XMGH	1	0
010T	02	PHYS/ATTY	15	00602	GM	84779810	BCB	XMGH	3	3
010T	03	PARALEGAL SPEC	09	00950	GS	84779810	BCB	XMGH	1	1
010T	04	LEGAL TECH (OA)	07	00950	GS	84779810	BCB	XMGH	1	0
010T	05	SECY (OA)	06	00318	GS	84779810	BCB	XMGH	1	1

SUBTOTAL

7 5

TOTAL

124 122

****GRAND TOTAL****

411 407

TDA HSXXXXXX
CCNUM HS0195
EDATE

HEADQUARTERS
US ARMY DENTAL COMMAND

SECTION I

1. CHANGES TO :

A. ACTIVATION: ACTIVATE US ARMY DENTAL COMMAND, FORT SAM
HOUSTON, TEXAS.

B. MODIFICATION:

C. RESCISSIONS:

D. SUPERSESIONS:

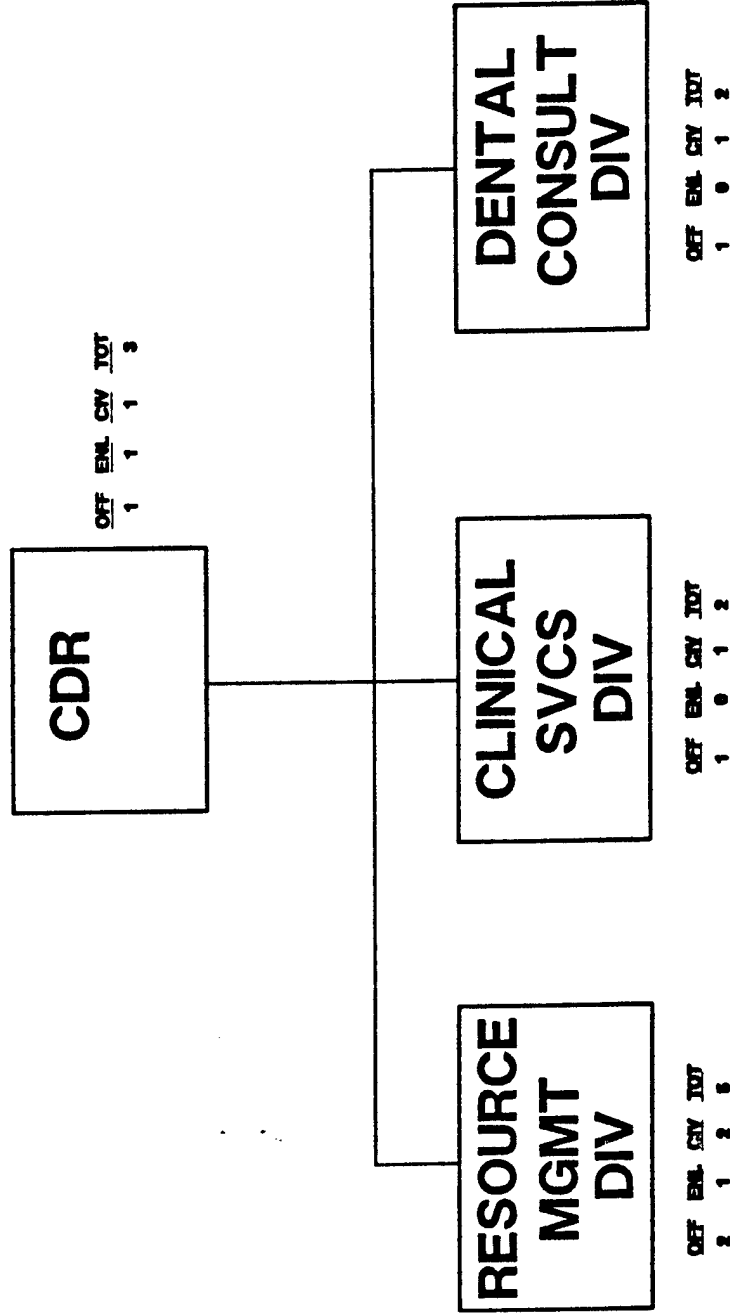
SECTION I.....

PREP. 920917 TDA HSXXXXXX
UNCLASSIFIED

HQS, US ARMY DENTAL COMMAND
FORT SAM HOUSTON, TEXAS

PROPOSED ORGANIZATION

HQ, U.S. ARMY DENTAL COMMAND



SUMMARY				
OFF	ENL	CIV	TOT	
5	2	5	12	

MYWORKSIDENPROP.DRW
BASG-HCM

2. LOCATION: FORT SAM HOUSTON, TEXAS 78234
3. ASSIGNMENT: US ARMY MEDICAL COMMAND
4. DATE OF LAST SURVEY
 - A. MANPOWER: NA
 - B. EQUIPMENT: NA
5. MISSION: THE US ARMY DENTAL COMMAND, A SUBORDINATE COMMAND OF THE US ARMY MEDICAL COMMAND, HAS RESPONSIBILITY FOR:
 - A. COMMAND AND CONTROL OF WORLDWIDE ARMY DENTAL SERVICE SYSTEM.
 - B. PROVISION OF DIRECTION AND LONG RANGE PLANNING FOR ARMY DENTAL ACTIVITIES.
 - C. ALLOCATION OF RESOURCES FOR THE OPERATION OF USADENCOM ORGANIZATIONS AND ACTIVITIES.

LAST PAGE OF SECTION 1

U.S. ARMY DENTAL COMMAND

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TDA HSXXXXXX
CCNUM HS0195
EDATE

HEADQUARTERS
US ARMY VETERINARY COMMAND

SECTION I

1. CHANGES TO :

A. ACTIVATION: ACTIVATE US ARMY VETERINARY COMMAND, FORT
SAM HOUSTON, TEXAS.

B. MODIFICATION:

C. RESCISSIONS:

D. SUPERSESIONS:

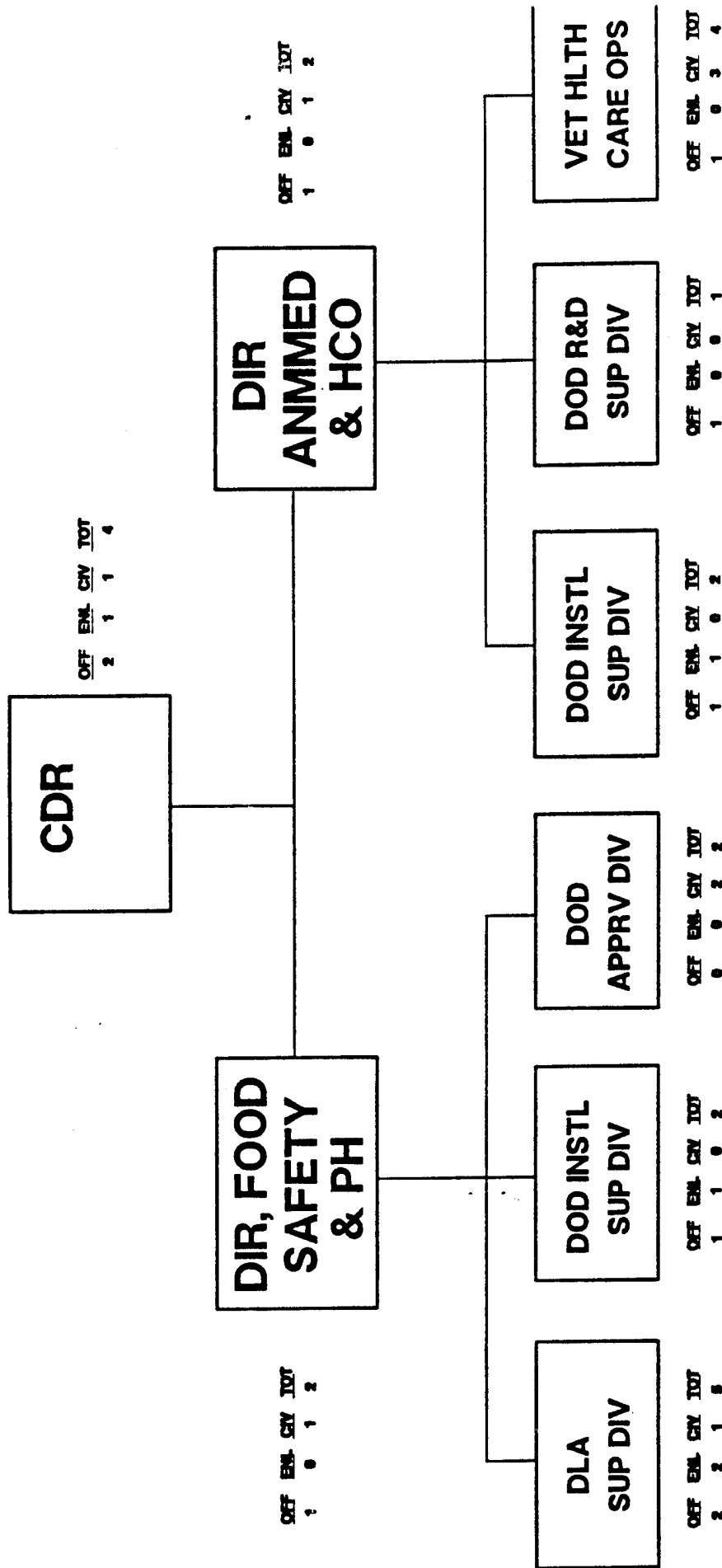
SECTION I.....

PREP. 920917 TDA HSXXXXXX
UNCLASSIFIED

HQS, US ARMY VETERINARY COMMAND
FORT SAM HOUSTON, TEXAS

PROPOSED ORGANIZATION

HQ, U.S. ARMY VETERINARY COMMAND



SUMMARY

OFF	ENL	CIV	TOT
10	5	9	24

MYWORKS\VETPROP.DRW
DASG-HCM

2. LOCATION: FORT SAM HOUSTON, TEXAS 78234

3. ASSIGNMENT: US ARMY MEDICAL COMMAND

4. DATE OF LAST SURVEY

A. MANPOWER: NA

B. EQUIPMENT: NA

5. MISSION: THE US ARMY VETERINARY COMMAND, A SUBORDINATE
COMMAND OF THE US ARMY MEDICAL COMMAND, HAS RESPONSIBILITY FOR:

A. COMMAND AND CONTROL OF WORLDWIDE VETERINARY SERVICE
SYSTEM.

B. PROVISION OF DIRECTION AND LONG RANGE PLANNING FOR
TRISERVICE VETERINARY MISSION.

C. ALLOCATION OF RESOURCES FOR THE OPERATION OF USAVETCOM
ORGANIZATIONS AND ACTIVITIES.

LAST PAGE OF SECTION 1

U.S. ARMY VETERINARY COMMAND

PARA	LN	POSITION OR DUTY TITLE	GR	POSCO	BR	ID	AMSCO	SWC	MDEP	REQ	AUTH
001	00	OFC OF THE CG	07	00B00	GO		84771424	HVJ	HSPV	1	0
001	01	CG							HSPV	0	1
001	01A	COMMANDER	06	64A00	VC		84771424	HVJ	HSPV	1	1
001	02	DCDR/COFS	06	64A00	VC		84771424	HVJ	HSPV	1	1
001	03	SR VET SVC NCO	E9	91R50	NC		84771424	HVJ	HSPV	1	1
001	04	SECY (OA)	07	00318	GS		84771424	HVJ	HSPV	1	1
SUBTOTAL											
002	00	DIR FD SAFETY & PH								4	4
002	01	DIR FDSEPH	06	64A00	VC		84771424	HVJ	HSPV	1	1
002	02	SECY (STENO)	05	00318	GS		84771424	HVJ	HSPV	1	1
SUBTOTAL											
002A	00	DLA SUP DIV								2	2
002A	01	C DLA S DIV	05	64A00	VC		84771424	HVJ	HSPV	1	1
002A	02	VET SVC TECH	W4	640A0	WO		84771424	HVJ	HSPV	1	1
002A	03	C VET SVC NCO	E8	91R50	NC		84771424	HVJ	HSPV	1	1
002A	04	VET SVC NCO	E7	91R40	NC		84771424	HVJ	HSPV	1	1
002A	05	QA SP SUB	11	01919	GS		84771424	HVJ	HSPV	1	1
SUBTOTAL											
002B	00	DOD INSTL SUP DIV								5	5
002B	01	M VET SVC TECH	W5	640A0	MW		84771424	HVJ	HSPV	1	1
002B	02	C VET SVC NCO	E8	91R50	NC		84771424	HVJ	HSPV	1	1
SUBTOTAL											
002C	00	DOD APPRV S DIV								2	2
002C	01	C DOD A S DIV	11	01801	GS		84771424	HVJ	HSPV	1	1
002C	02	SAN COMP ASST	06	01802	GS		84771424	HVJ	HSPV	1	1

****SUBTOTAL****

003	00	DIR ANMED&HLTHCAREOPS
003	01	DIR AM&HC OPS
003	02	SECY (OA)

****SUBTOTAL****

003A	00	DOD INSTL SUP DIV
003A	01	C DOD I S DIV
003A	02	SR AN CARE NCO

★★SUBTOTAL★★

003B 00 DOD R&D SUP DIV
003B 01 C DOD R&D DIV

****SUBTOTAL****

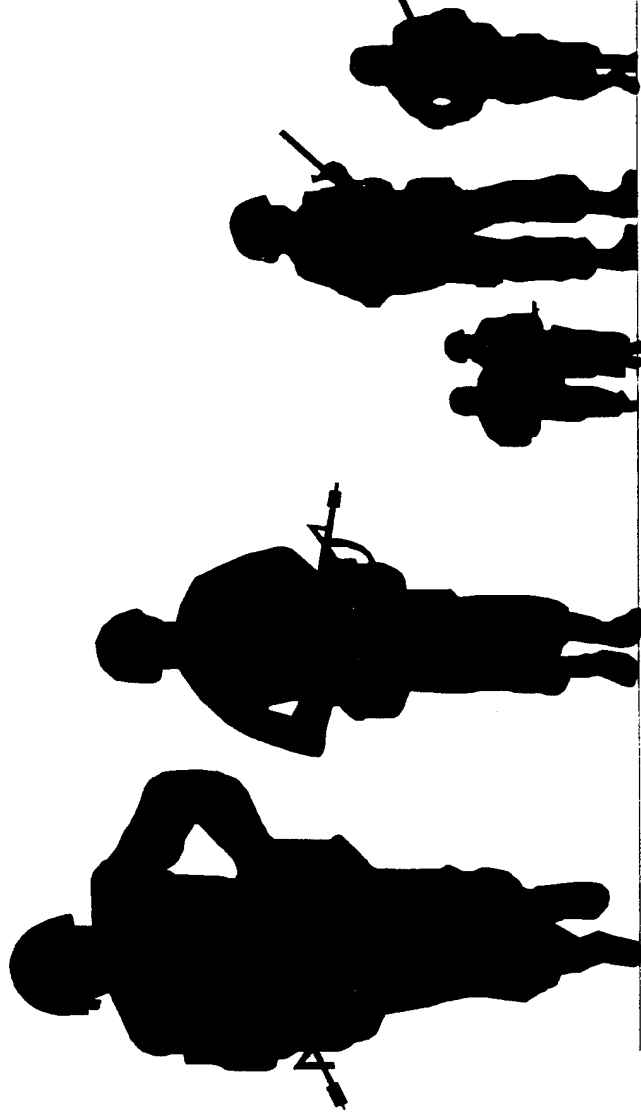
003C	00	VET HLTH CARE OPS
003C	01	C VET H C OPS
003C	02	VET OPNS SP
003C	03	VET MGT ANALYST
003C	06	OA CLERK

****SUBTOTAL****

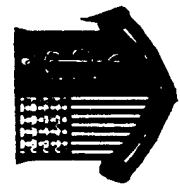
TOTAL

ENCLOSURE 7

OUT FRONT AND MOVING!



**Task Force Aesculapius
US Army Medical Department**

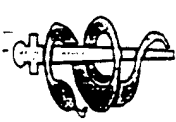


AMEDD Design Principles &

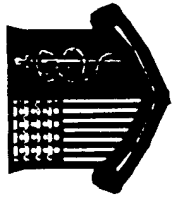
- Establish clear accountability and align with authority
- Organize around work
- Get people working on the right tasks at the right level
- Eliminate duplication and redundancy
- Value-added



The Future Army



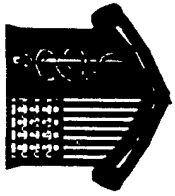
- Smaller Army
- CONUS based
- Quick reaction - trained and ready
- Force Projection
- Balanced force mix - active and reserve
- New missions



National Health Care



- Accountable Health Plans - Health Alliances
- Universal access - transportable coverage
- Standard benefit package
- Health Insurance Purchasing Co-operatives
- Competition on quality and cost
- Accountability and Assessment



Other Planning Considerations



- Tri-Service jointness
- Federal-ness
- Team centered wellness model
- Cost and growth of technology
- BRAC
- CRI-like benefit packages
- Continuing contractor involvement

FOCUS OF CHANGE

DEFEAT
BUREAUCRACY &
PAROCHIALISM

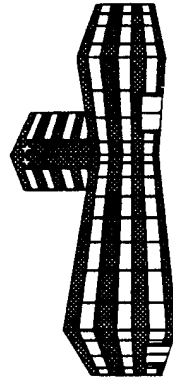
CAPITALIZE
ON TECHNOLOGY

READINESS

READY FOR WAR

and

READY FOR PEACE



INTEGRATED AMEDD - SEAMLESS TRANSITION

CHANGE
AMEDD
CULTURE

ENHANCE
GATEWAY
TO CARE

SHIFT TO
TEAM-CENTERED
WELLNESS MODEL

SUPPORTING THE ARMY FAMILY

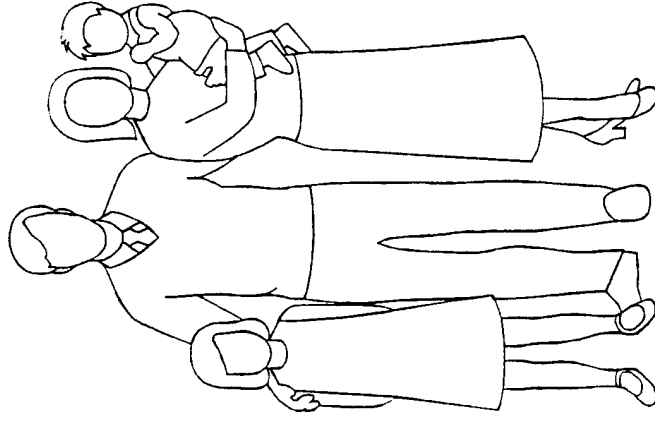
UNCERTAINTY

DOWNSIZING
STRESS

NATIONAL
HEALTH
REFORM

CRI, CAM,
OTHER DEMO
PROJECTS

PAY
FREEZE



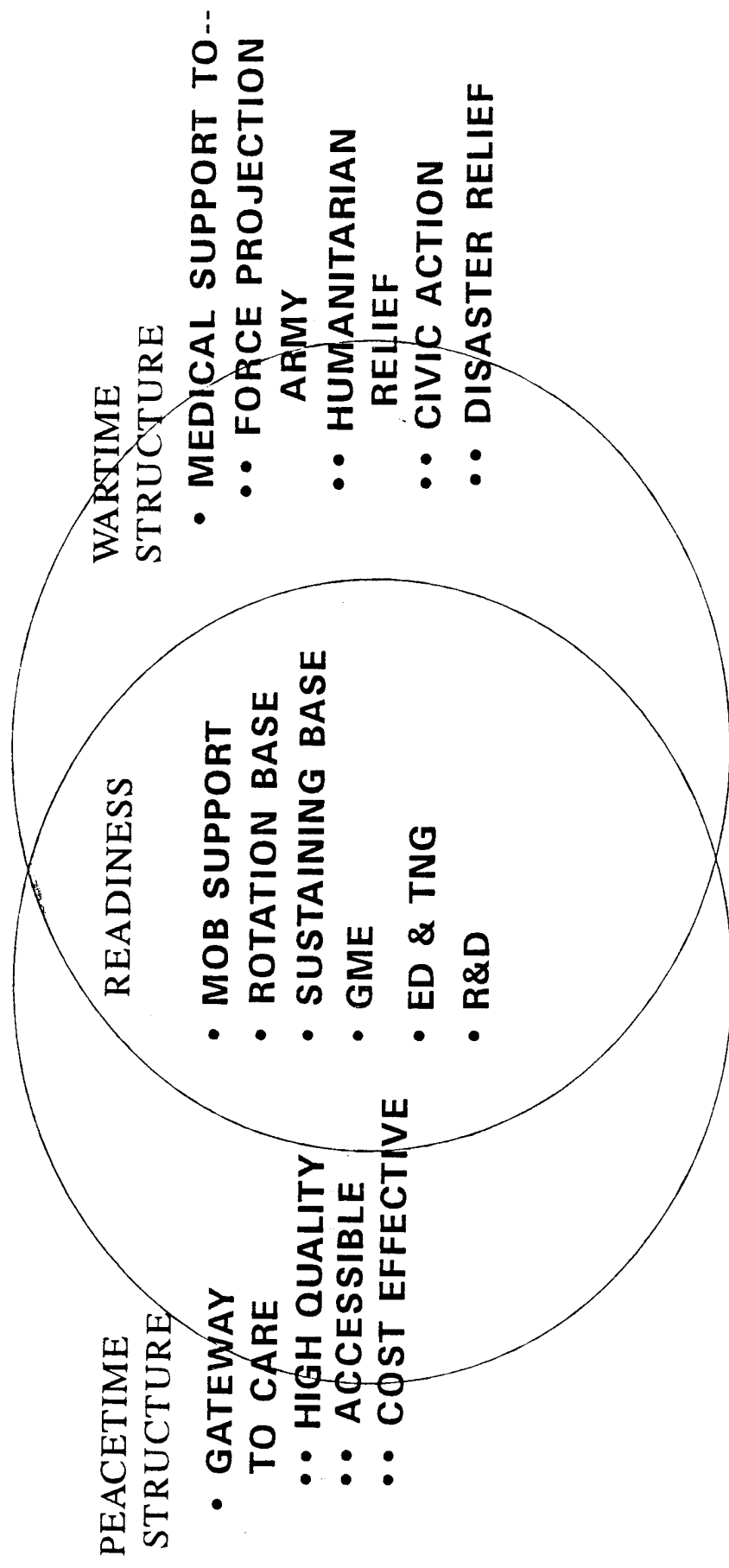
PRESERVE AND ENHANCE THE
MILITARY HEALTH CARE BENEFIT

THE ARMY'S MEDICAL DEPARTMENT

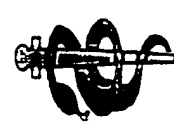
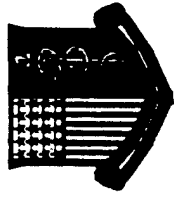
ACCESSIBLE

DEPLOYABLE

ACCOUNTABLE



**THE AMEDD - AN INTEGRATED, ORGANIZED
SYSTEM OF CARE**



Competitive Features of Army Medicine

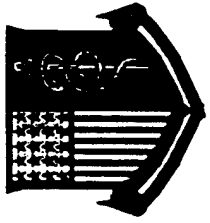
- Organized system of care
- Integrated
- Accountable
- Operating in all settings



ONE ARMY MEDICAL DEPARTMENT



- TOE - TDA - Reserve integration
- Poised for the future
- Efficient training resource
- Operating worldwide

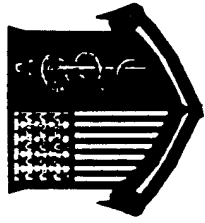


CORE PRINCIPLES

The Surgeon General



- High quality, affordable health care
- Fully trained, ready, deployable AMEDD
- Value added
- Unity of command
- Stakeholder buy-in
- Authority commensurate with responsibility



CORE PRINCIPLES

The Surgeon General

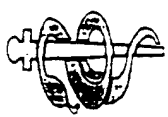


(continued)

- Span of control
- Plan accommodates predictable futures
- Development of talent pool
- Capitalize on emerging technologies
- Effective communication
- Accountability



THE BUSINESS PLAN



- Integrates:
 - ▶ Paradigms I - V
 - ▶ Cost of peacetime competition
 - ▶ Cost of wartime readiness
- Focuses planning and operations at all levels

**THE OTSG,
MEDCOM AND REGIONAL
HEADQUARTERS ARE**

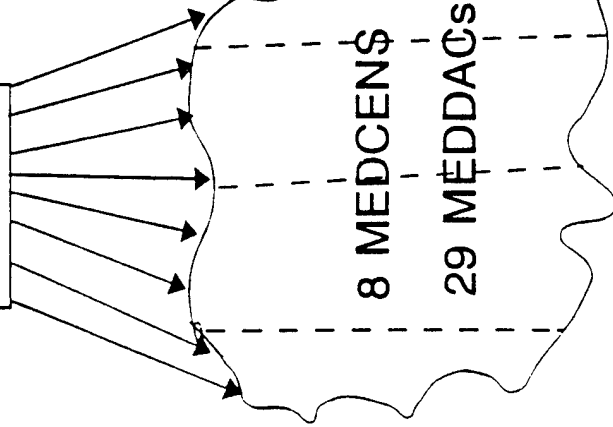
NEW

PRESENT

CSA

OTSG

HSC



COMPRESSED

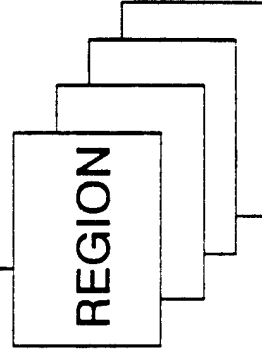
SLICED

FUTURE

CSA

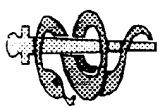
OTSG

USAMEDCOM





OTSG DESIGN PRINCIPLES



- Assists CSA and SEC Army in developing ARMY policy
- Acquires resources
- Represents and promotes AMEDD
- No In-Boxes



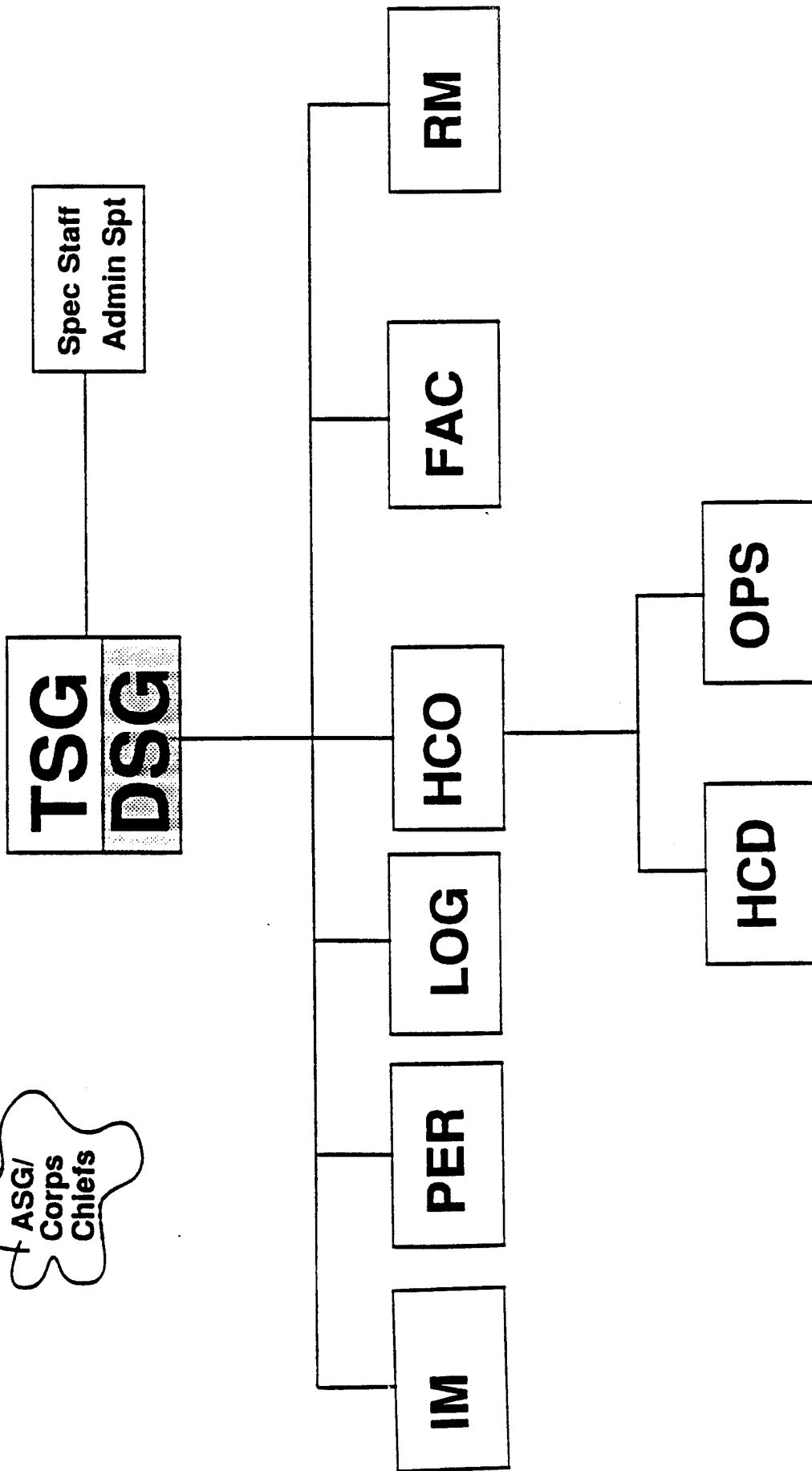
OTSG MISSION



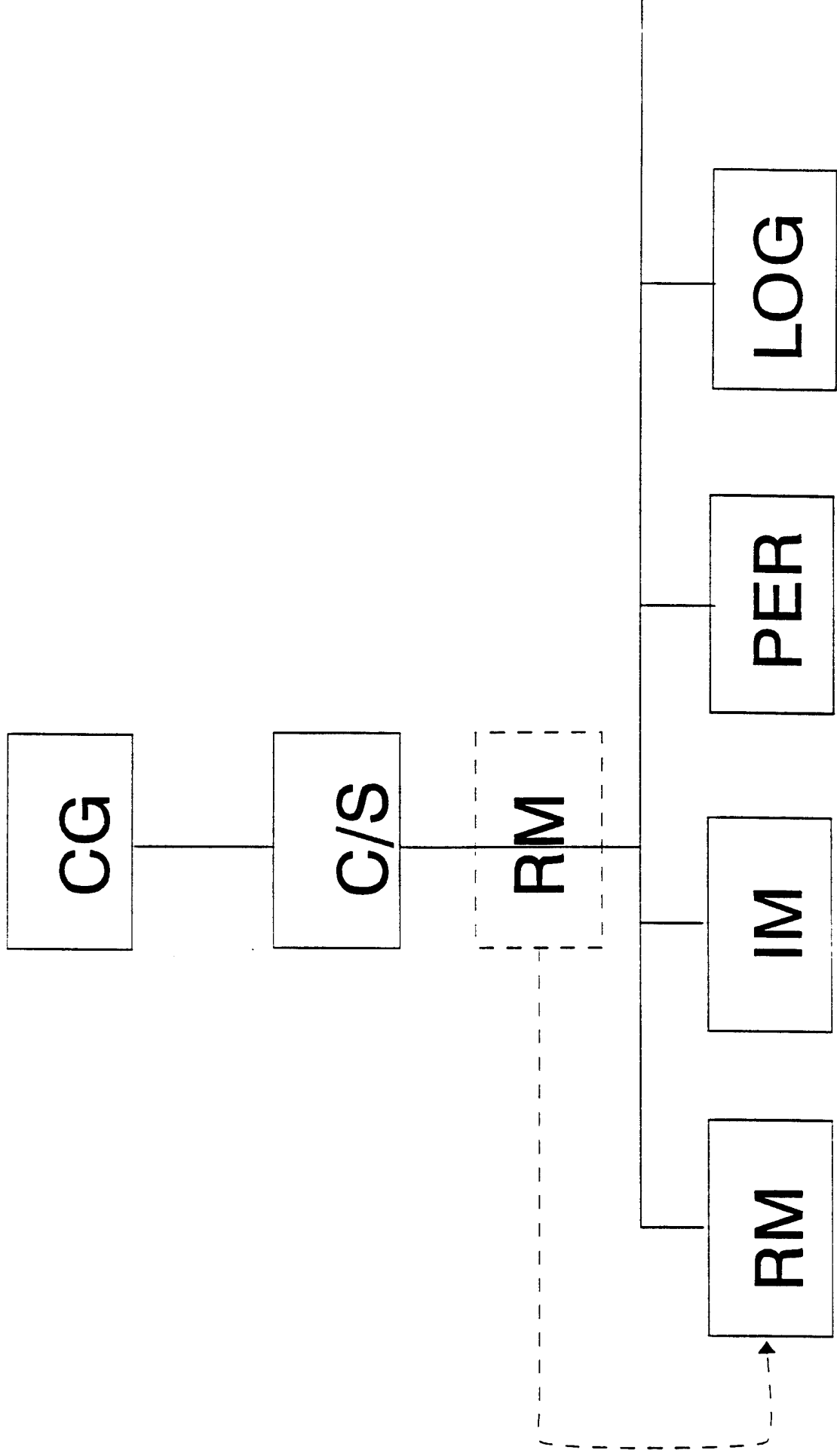
- Assist CSA and Sec Army in discharging Title 10 responsibility.
- Advise and assist CSA and Sec Army and other principle officials on all matters pertaining to the Military Health Service System.
- Represent the Army to the Executive Branch, Congress, DoD Agencies and other organizations on all health policies affecting the AMEDD.
- Represent and promote AMEDD resource requirements.

OTSG

ASG/
Corps
Chiefs

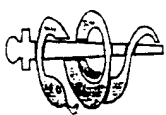


MEDCOM

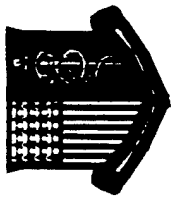




MEDCOM DESIGN PRINCIPLES



- Center of AMEDD policy, planning and operations
- Worldwide scope
- Focus on Strategic Business Planning
- Analytical capability for effective assessment and continuous improvement
- Directive authority and functions shifted from OTSG

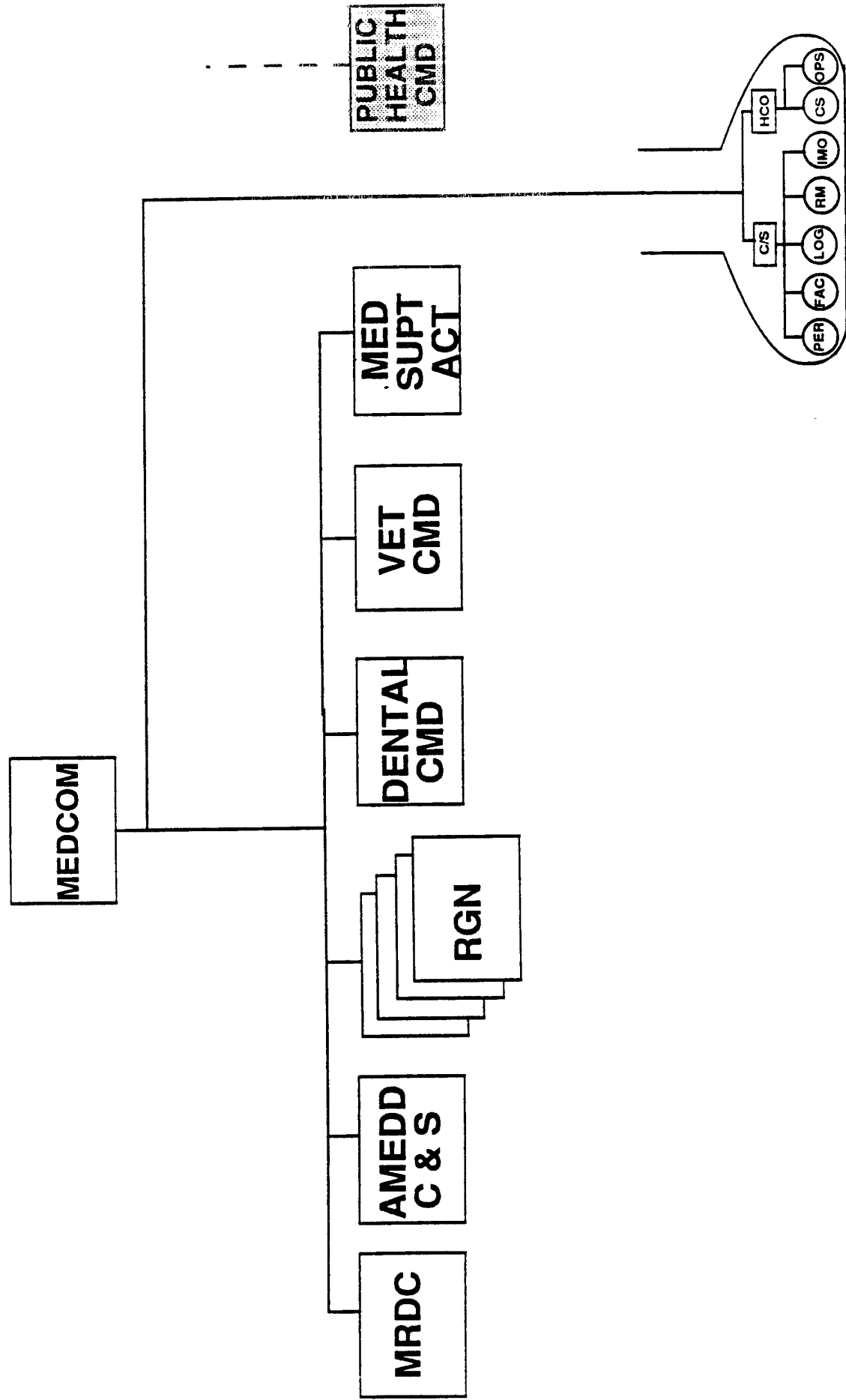


MEDCOM MISSION



- Command and control of worldwide Army Health Service System.
- Provide vision, direction, and long range planning for the AMEDD.
- Develop and integrate doctrine, training, leader development, organization, and materiel for the Army Health Service System.
- Allocate resources, analyze utilization and assess performance worldwide.

MEDCOM

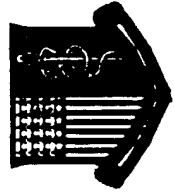




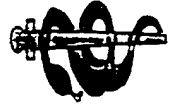
REGION DESIGN PRINCIPLES



- Health care delivered here
- Primary integrator of paradigms I, II, and III
- Compete in local markets
- Focus on Operational Business Planning

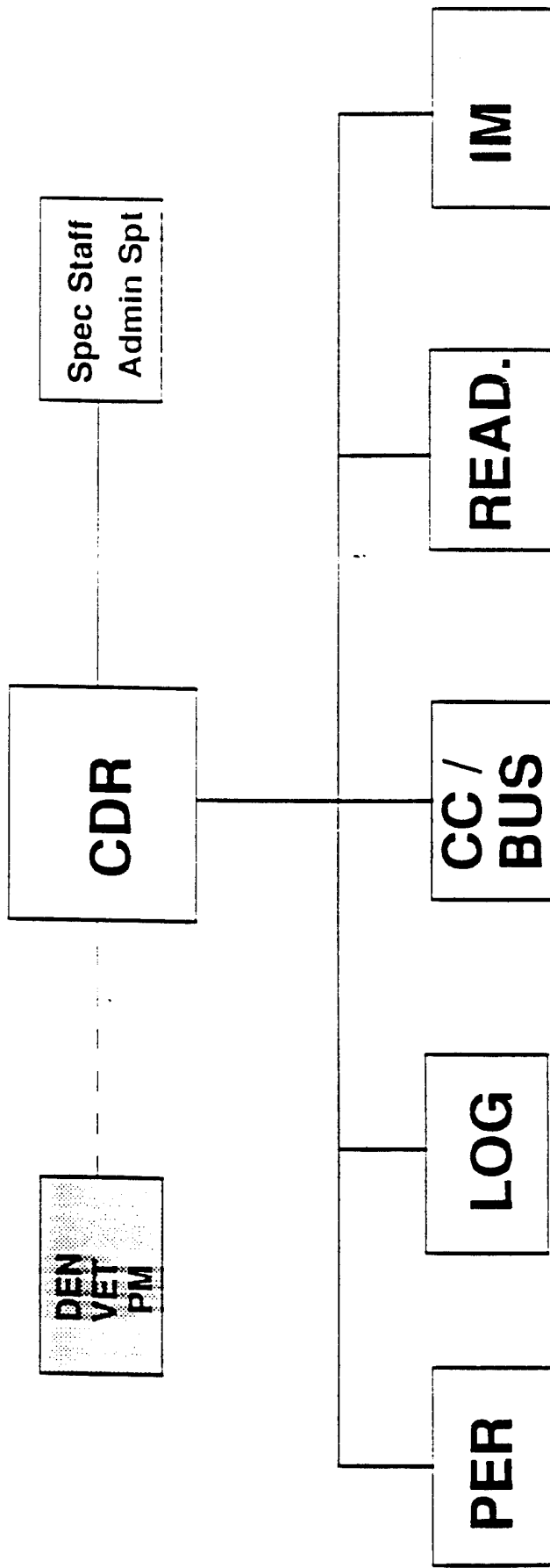


REGION MISSION

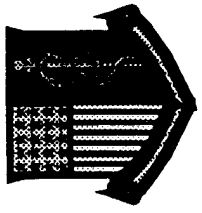


- Regional command and control of a cost effective, multi-disciplinary, customer-focused, quality Military Health Service System.
- Develop and sustain technical health care and leader skills in support of USAMEDCOM readiness goals in an integrated Army Health Service System.
- Support the readiness requirements of The Total Force.
- Allocate resources, analyze utilization and assess performance across the Region.

REGION HQ



(Designed to meet local market conditions)



TSG PLANNING POINTS



- Size
 - ▶ OTSG: 80 - 100
 - ▶ MEDCOM: 350 -400 (minimum FOAs)
 - ▶ Regions: about 130 total
- Focus
 - ▶ Shifted functions across MEDCOM
 - ▶ Aligned functions with appropriate levels of work
 - ▶ Aligned authority with responsibility
 - ▶ Applied accountability throughout system
 - ▶ Realigned consultants
 - ▶ Moved GME/GDE to AC&S

AMEDD REORGANIZATION PLAN

AIMING STAKES

REQUISITE AMEDD
FY 96-97

REGIONS

FOUR CONUS

REPORT TO MEDCOM

CDR IS GEN OFFICER

MEDCOM

MELD OTSG, HSC, HPSC

CDR (LTG) & CMD IN FSHT

(APPROX 350-400)

OTSG

IN THE PENTAGON

(LESS THAN 100)

STRATEGIC FOCUS

• AMEDD POLICY

• WORLDWIDE SCOPE

• INTEGRATES

PARADIGMS I-V

• REP & DEFEND AMEDD

• ACQUIRE RESOURCES

• LIAISON WITH MEDCOM

• NO IN-BOXES

OPERATIONAL FOCUS

• SMALL STAFF

• INTEGRATES

PARADIGMS I-III

PARADIGMS:

I - TOE

II - MED MOB

READINESS

III - HEALTH CARE

DELIVERY

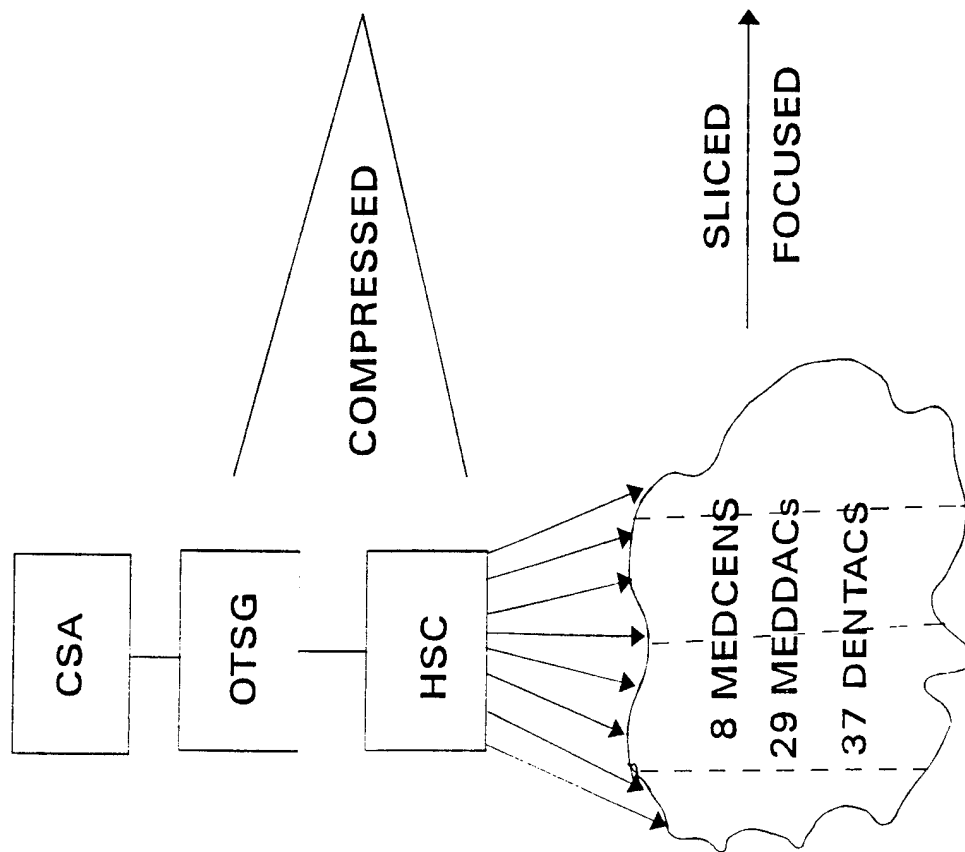
IV - DOCTRINE, TNG

CBT DEV

V - RDA

AMEDD RESTRUCTURING CONCEPT

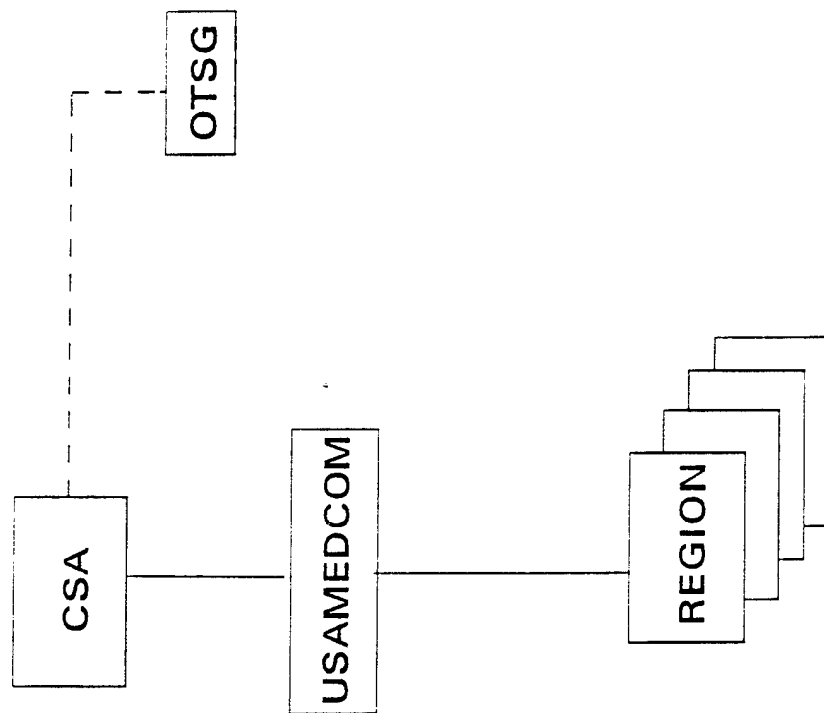
PRESENT



SLICED

FOCUSED

FUTURE



RESULT

PREPARED
FOR
FUTURE

SMALLER C&C
STRUCTURE

IMPROVED
READINESS

FUNCTIONALLY
ORGANIZED
AMEDD

FOCUSED
ON
CUSTOMERS

READINESS: THE FUNDAMENTAL REASON
FOR MILITARY MEDICINE

ISSUES

ARSTAF
BEHAVIOR
CHANGE

733 STUDY
——
BOTTOM-UP
REVIEW

WORLDWIDE
SCOPE -
OCONUS
INTEGRATION

HEALTH
CARE
REFORM

RETURN
TO
PENTAGON

INTEGRATION
OF
TOE

ENCLOSURE 8

AMEDD REORGANIZATION



A BRIEFING TO THE ARMY STAFF
8 JULY 1993

TASK FORCE AESCULAPIUS

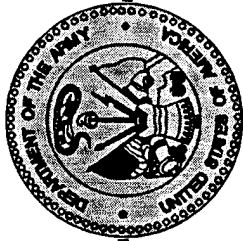


PURPOSE OF BRIEFING

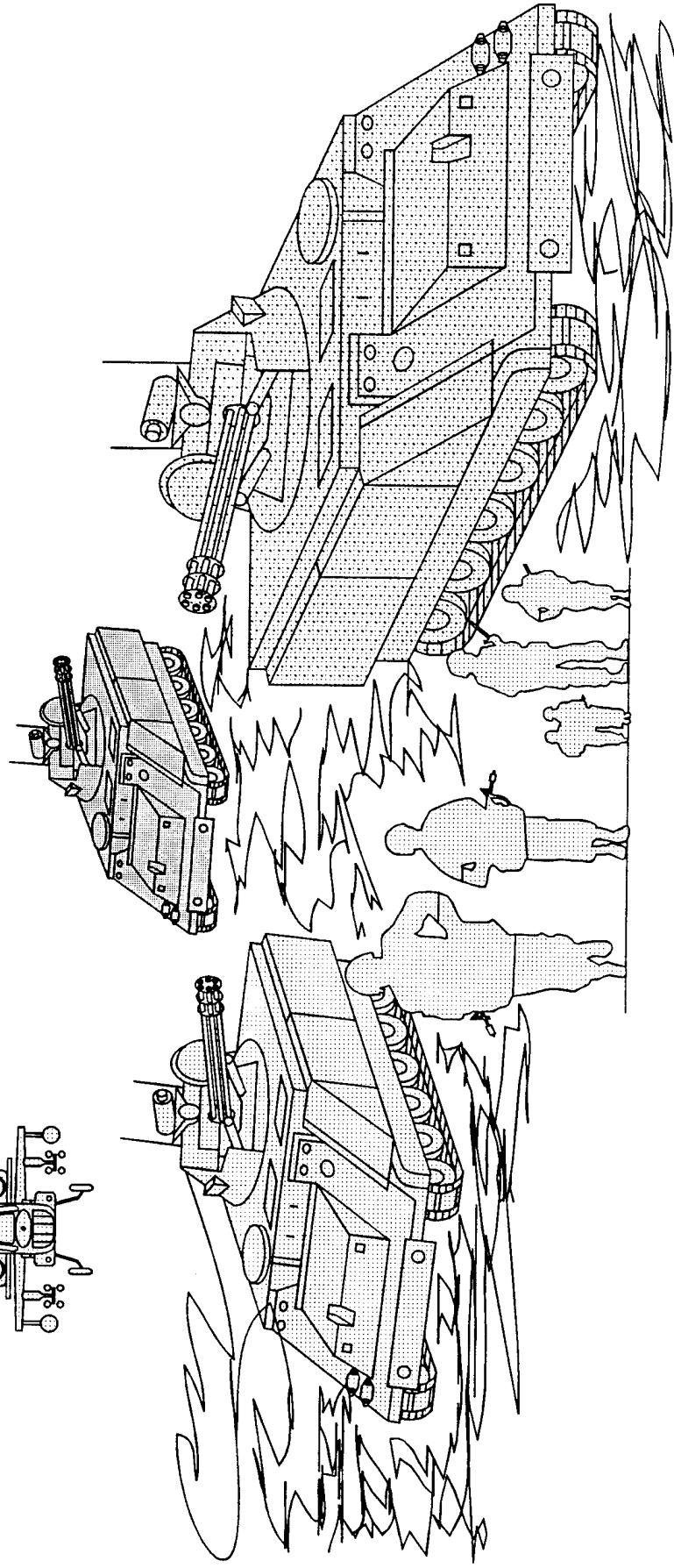
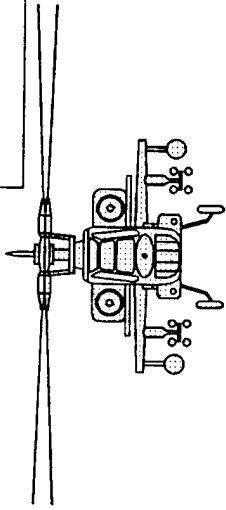
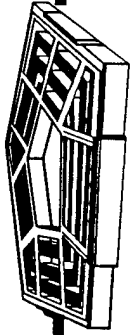
- PRESENT AMEDD COMMAND AND CONTROL RESTRUCTURING PLAN
- DESCRIBE CONTRIBUTION TO HQDA TRANSFORMATION STUDY
- SEEK COMMENTS PRIOR TO FORMAL STAFFING AND PRESENTATION TO CSA

TASK FORCE AESCULAPIUS





HQDA TRANSFORMATION STUDY



HQDA TRANSFORMATION STUDY

CLOSE HOLD

SUMMARY

SURGEON GENERAL

TASK FORCE AESCULAPIUS EXPECTED TO ACHIEVE SIGNIFICANT SAVINGS.
DIRECT TSG TO REPORT RESULTS IN JULY 93.

HQDA TRANSFORMATION STUDY

CLOSE HOLD

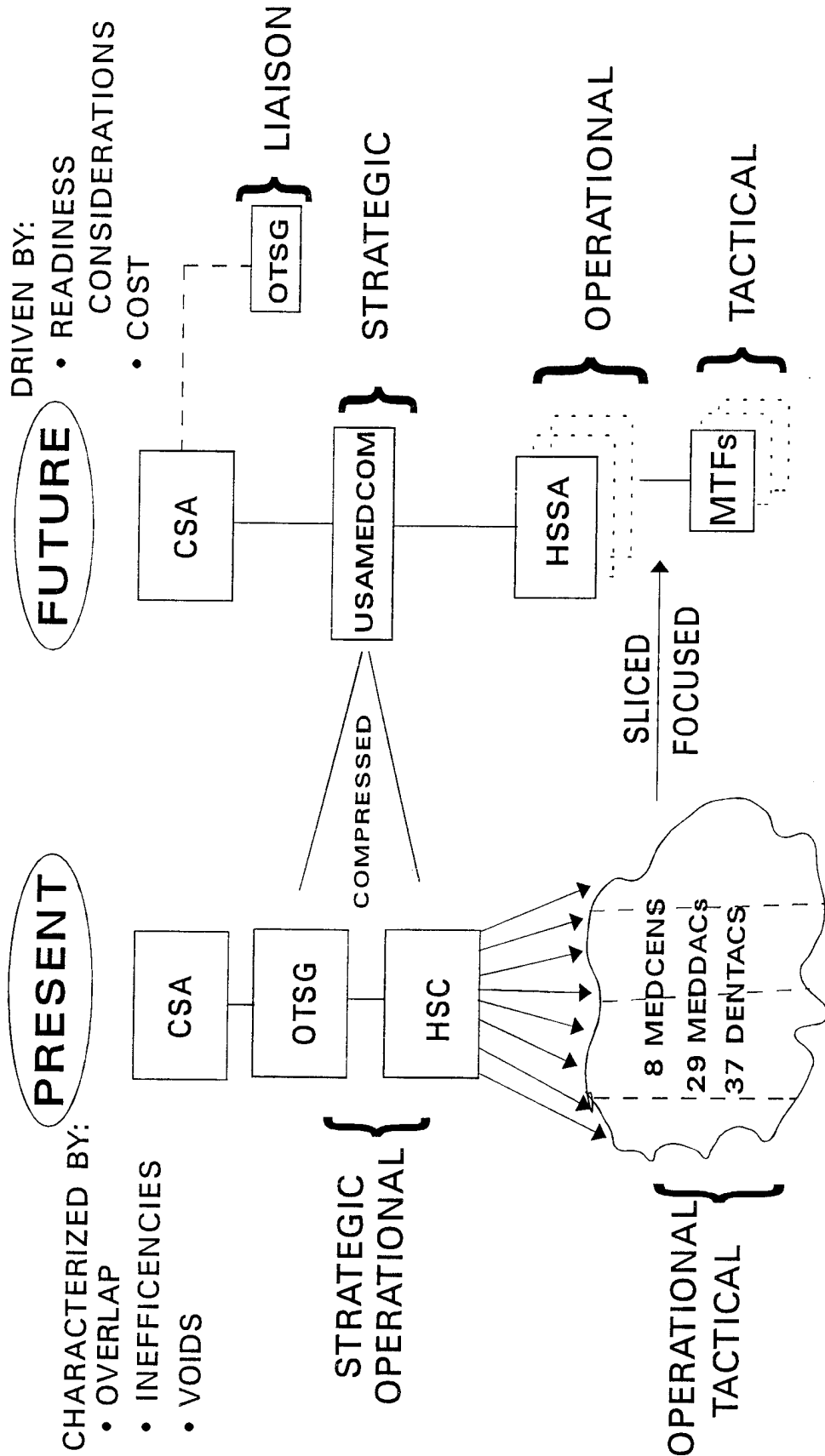
AMEDD COMMAND & CONTROL ISSUES

- AUTHORITY NOT ALIGNED WITH RESPONSIBILITY
- REDUNDANT ORGANIZATIONS
- DUPLICATED MISSIONS AND FUNCTIONS
- STRATEGIC AND OPERATIONAL WORK MIXED AT SEVERAL LEVELS
- INAPPROPRIATE SPANS OF CONTROL
- GROWTH OF BUREAUCRACY

TASK FORCE AESCULAPIUS



AMEDD REORGANIZATION PROPOSAL



TASK FORCE AESCULAPIUS

AMEDD REORGANIZATION OBJECTIVES

- "WORLD CLASS" COMBAT CASUALTY CARE
- HIGH QUALITY, COST EFFECTIVE HEALTH CARE FOR SOLDIERS, DEPENDENTS AND AUTHORIZED BENEFICIARIES
- FULLY INTEGRATED ARMY MEDICAL DEPARTMENT

TASK FORCE AESCULAPIUS 

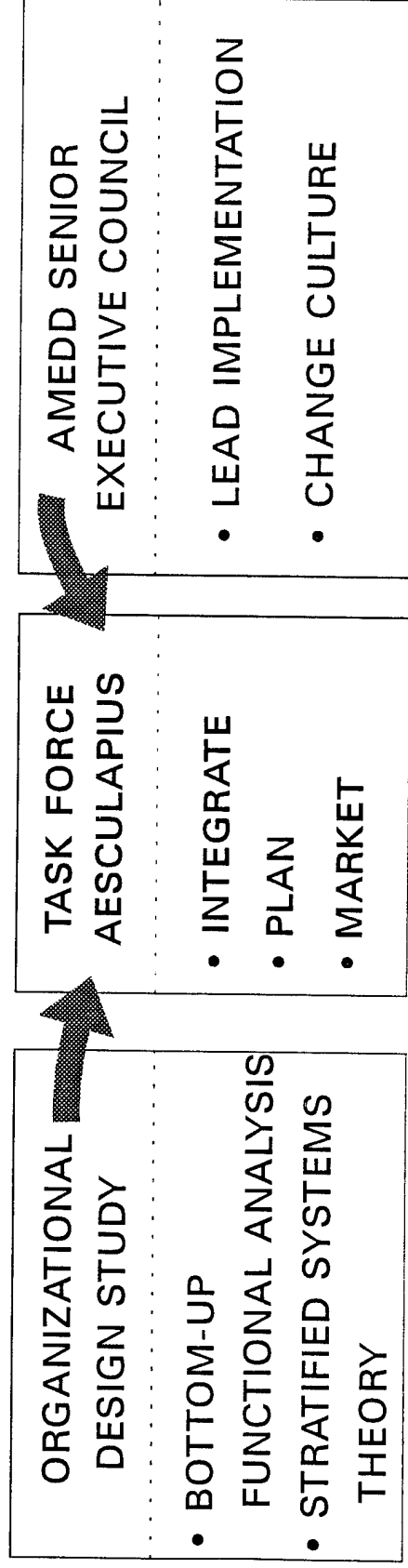
ORGANIZATIONAL DESIGN PRINCIPLES

- ORGANIZE AROUND WORK
 - ▶ STRATEGIC
 - ▶ OPERATIONAL
 - ▶ TACTICAL
- ESTABLISH CLEAR ACCOUNTABILITY AND AUTHORITY
- CONCENTRATE ON CORE BUSINESS
- FOCUS ON THE CUSTOMER

TASK FORCE AESCULAPIUS



CHANGE AGENTS

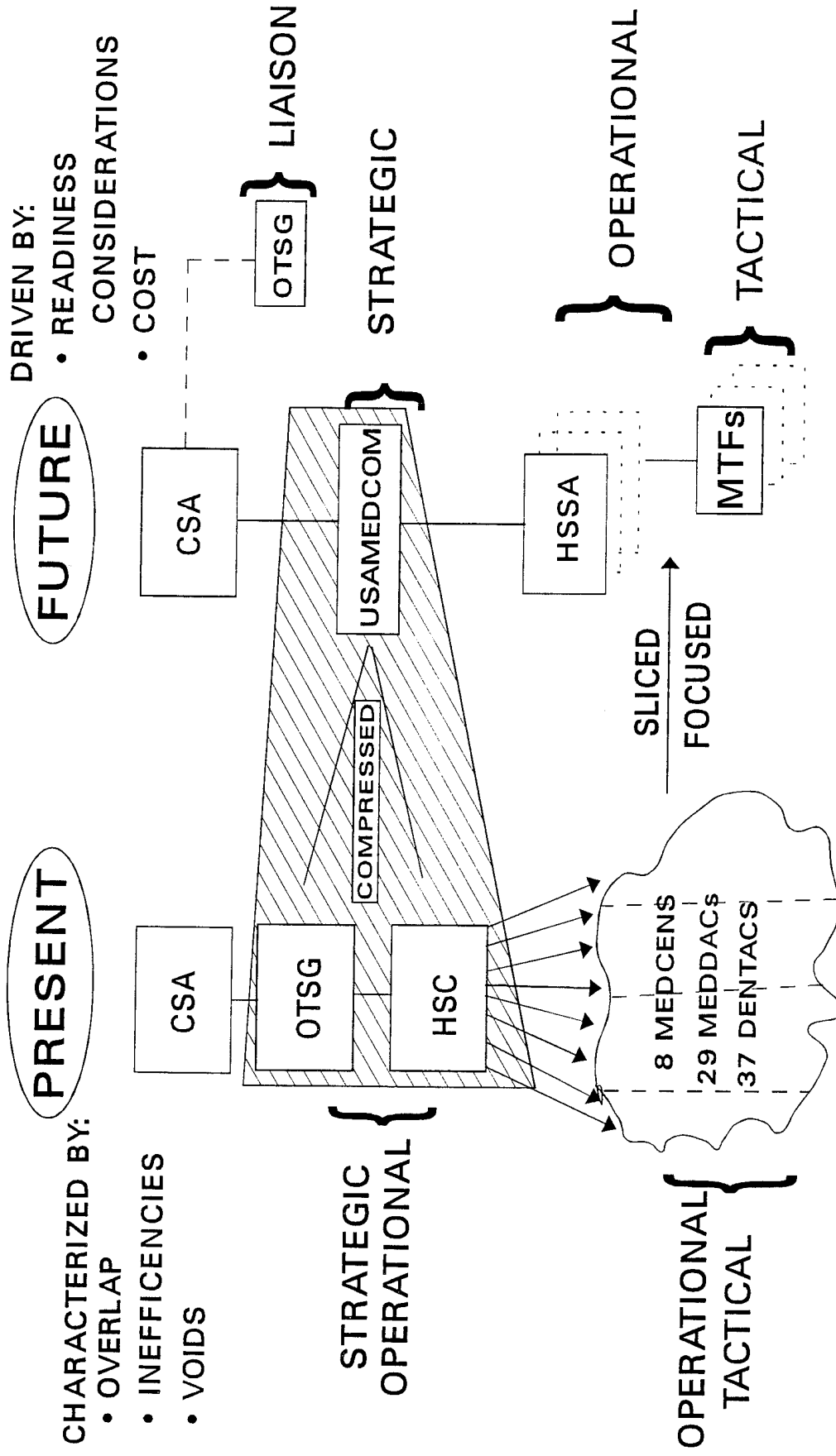


GOAL:

- FULLY TRAINED, READY, DEPLOYABLE AMEDD
- HIGH QUALITY, AFFORDABLE HEALTH CARE

TASK FORCE AESCULAPIUS 

AMEDD REORGANIZATION PROPOSAL



TASK FORCE AESCULAPIUS

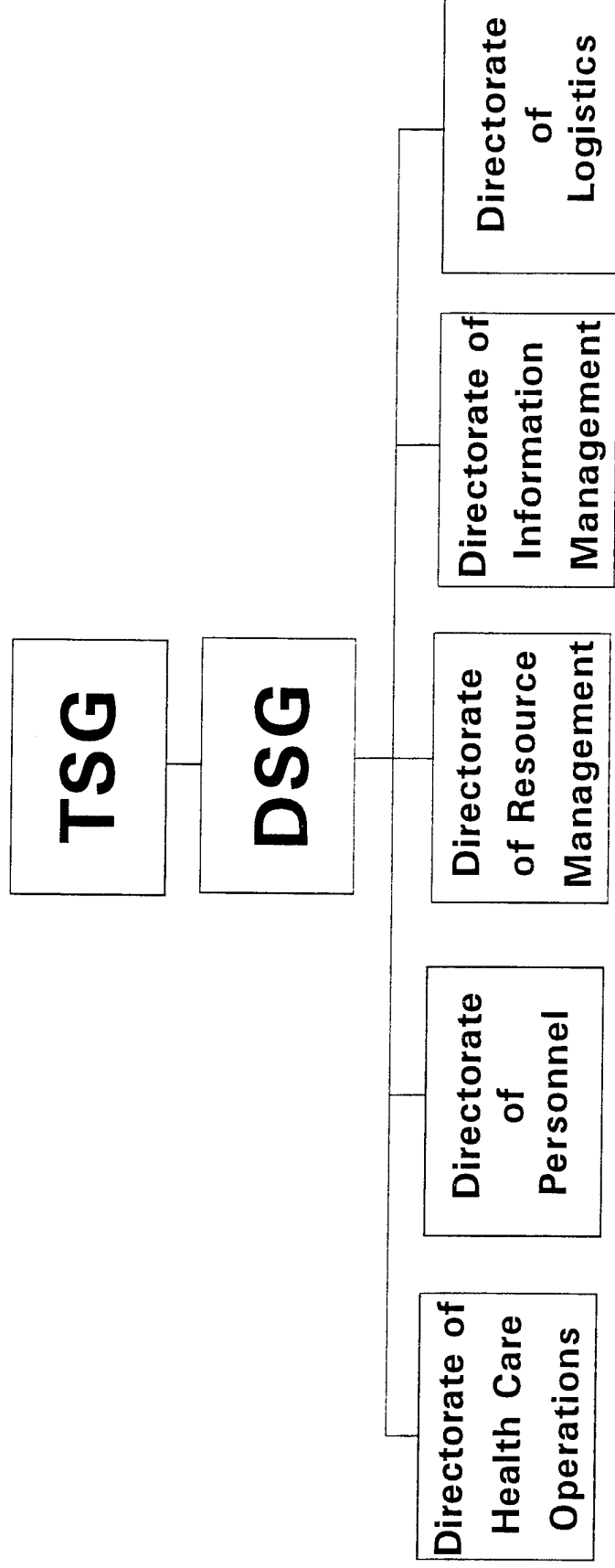
OTSG MISSION

- ASSIST CSA AND SEC ARMY IN DISCHARGING TITLE 10 RESPONSIBILITY
- ADVISE AND ASSIST CSA AND SEC ARMY AND OTHER PRINCIPAL OFFICIALS ON ALL MATTERS PERTAINING TO THE MILITARY HEALTH SERVICE SYSTEM
- REPRESENT THE ARMY TO THE EXECUTIVE BRANCH, CONGRESS, DOD AGENCIES AND OTHER ORGANIZATIONS ON ALL HEALTH POLICIES AFFECTING THE AMEDD
- REPRESENT AND PROMOTE AMEDD RESOURCE REQUIREMENTS

TASK FORCE AESCULAPIUS



PROPOSED OTSG ORGANIZATION



TOTAL AUTHORIZATIONS = 100

TASK FORCE AESCULAPIUS



AMEDD

COMMAND & CONTROL STRUCTURE

AUTHORIZATIONS

	1993	1997
--	------	------

OTSG	128	425
HPSA	297	100

REDUCED PRESENCE IN NCR

% CHANGE = -76.5%

TASK FORCE AESCULAPIUS



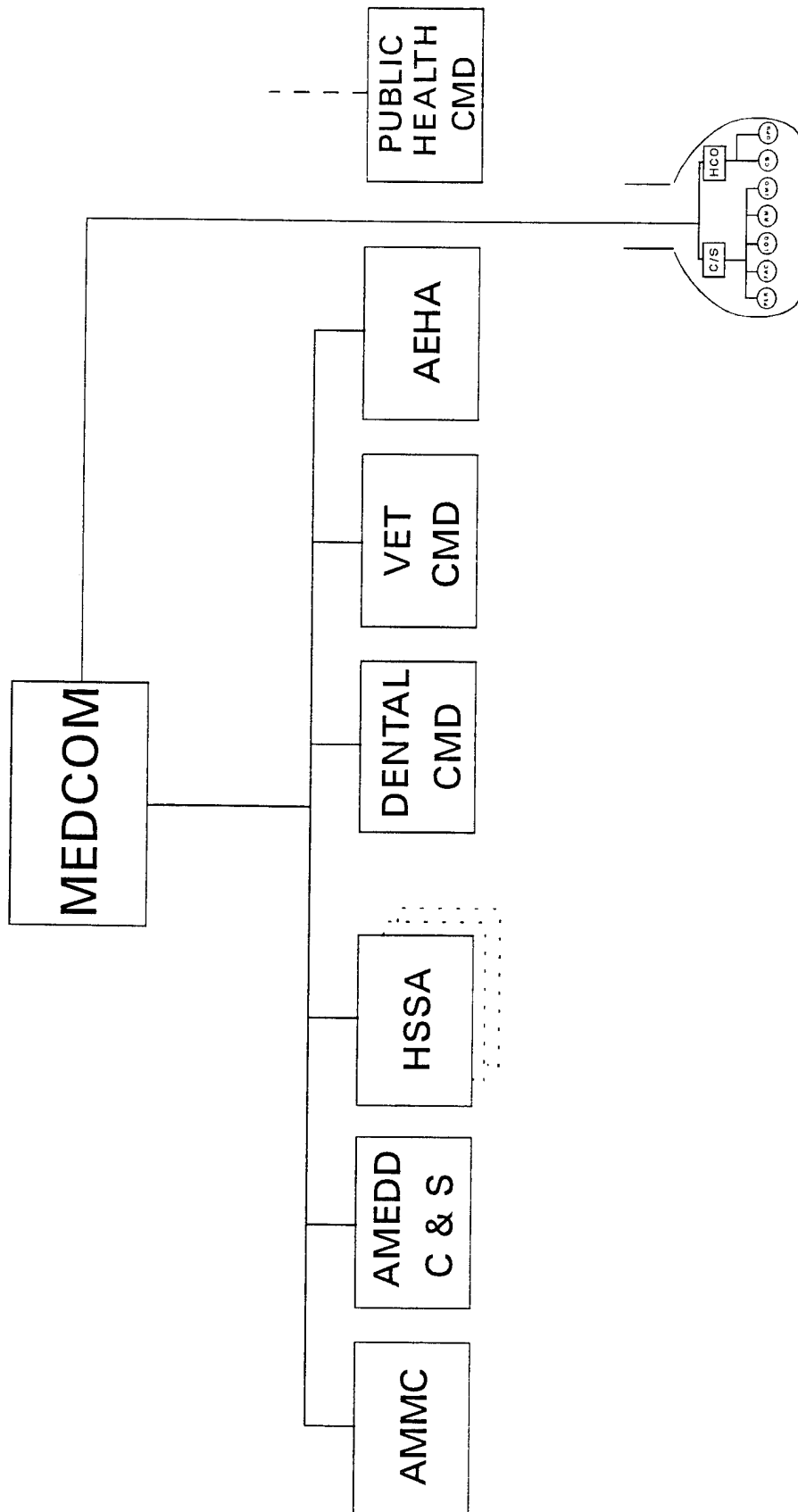
MEDCOM MISSION

- COMMAND AND CONTROL OF WORLDWIDE ARMY HEALTH SERVICE SYSTEM
- PROVIDE VISION DIRECTION AND LONG RANGE PLANNING FOR THE AMEDD
- DEVELOP AND INTEGRATE DOCTRINE, TRAINING, LEADER DEVELOPMENT, ORGANIZATION, AND MATERIEL FOR THE ARMY HEALTH SERVICE SYSTEM
- ALLOCATE RESOURCES, ANALYZE UTILIZATION AND ASSESS PERFORMANCE WORLDWIDE

TASK FORCE AESCULAPIUS



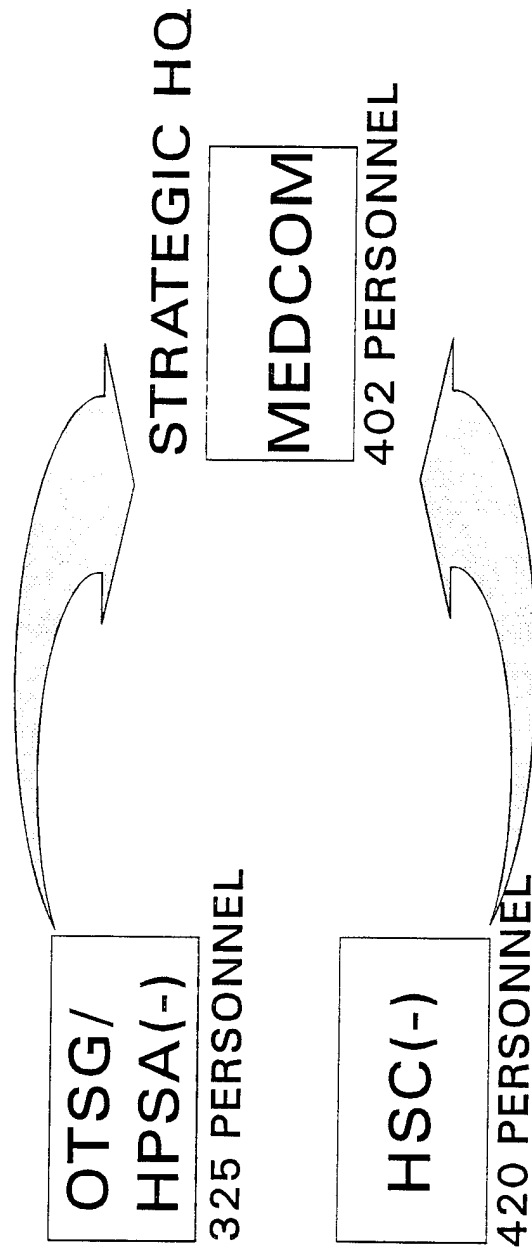
MEDCOM



TASK FORCE AESCULAPIUS



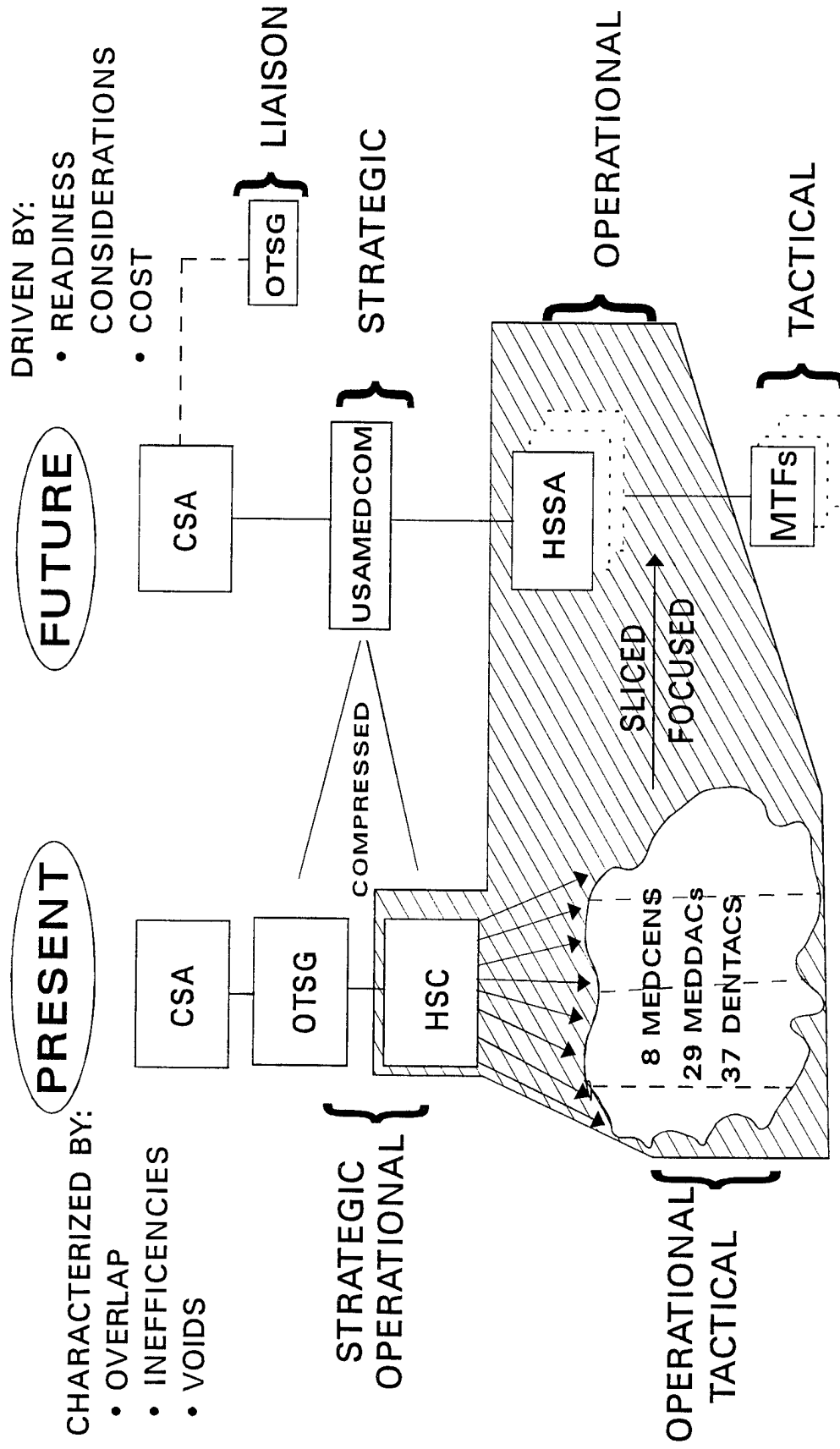
MEDCOM STRATEGIC COMMAND & CONTROL



% CHANGE = -46%

TASK FORCE AESCULAPIUS

AMEDD REORGANIZATION PROPOSAL



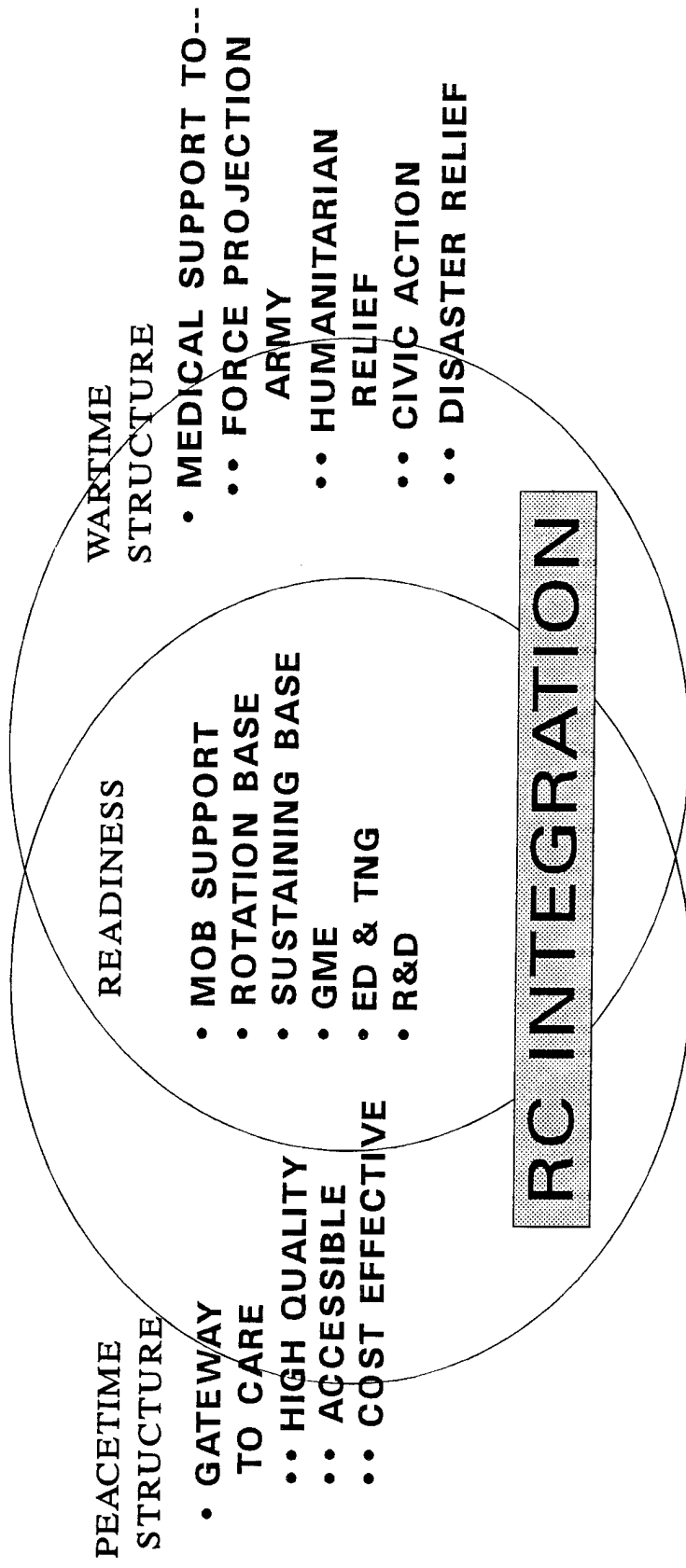
TASK FORCE AESCULAPIUS

THE ARMY'S MEDICAL DEPARTMENT

ACCESSIBLE

DEPLOYABLE

ACCOUNTABLE



ONE AMEDD - AN INTEGRATED, ORGANIZED
SYSTEM OF CARE


TASK FORCE AESCULAPIUS

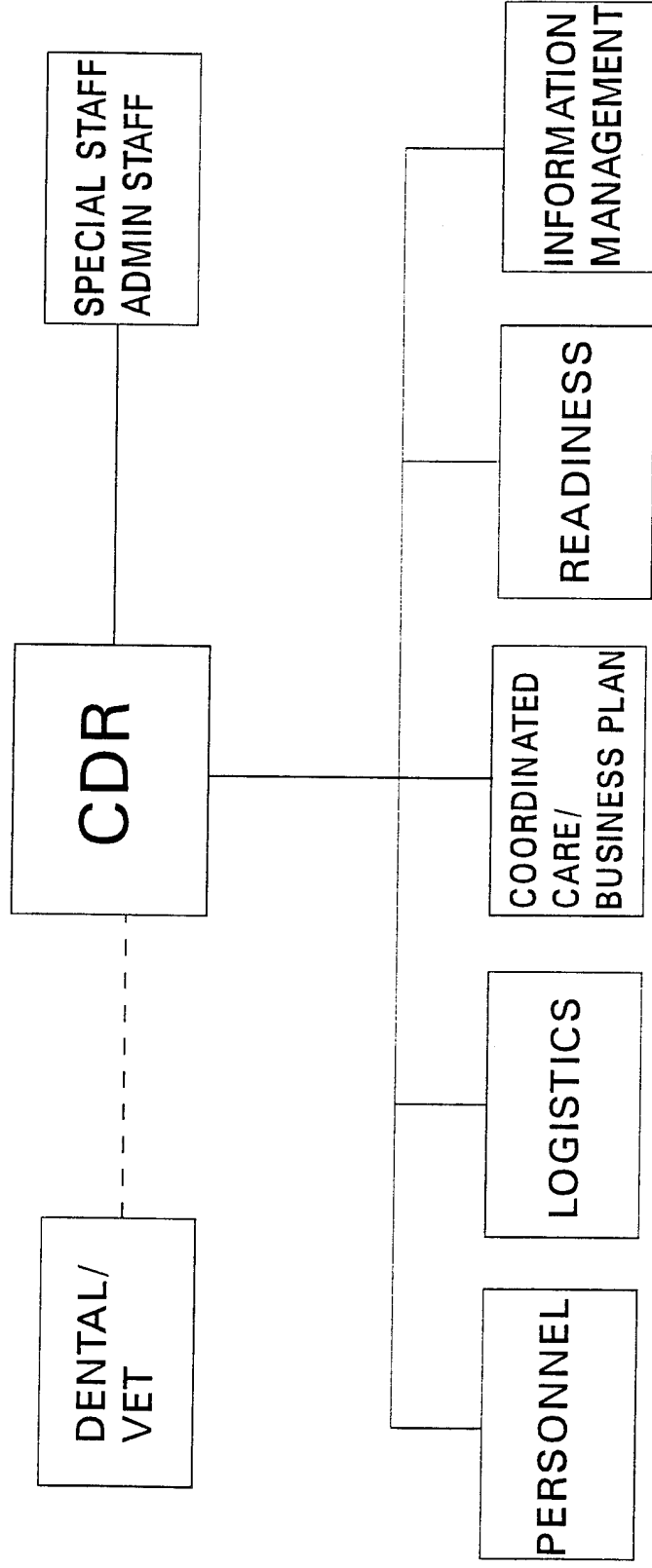
HSSA MISSION

- REGIONAL COMMAND AND CONTROL OF A COST EFFECTIVE, MULTI-DISCIPLINARY, CUSTOMER-FOCUSED, QUALITY MILITARY HEALTH SERVICE SYSTEM
- SUPPORT THE READINESS REQUIREMENT OF THE TOTAL FORCE
- DEVELOP AND SUSTAIN TECHNICAL HEALTH CARE AND LEADER SKILLS IN SUPPORT OF USAMEDCOM READINESS GOALS IN AN INTEGRATED ARMY HEALTH SERVICE SYSTEM
- ALLOCATE RESOURCES, ANALYZE UTILIZATION AND ASSESS PERFORMANCE ACROSS THE HSSA

TASK FORCE AESCULAPIUS



HEALTH SERVICE SUPPORT AREA HQ

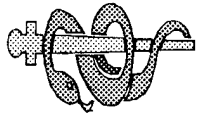
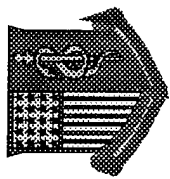


(DESIGNED TO MEET LOCAL MARKET CONDITIONS)

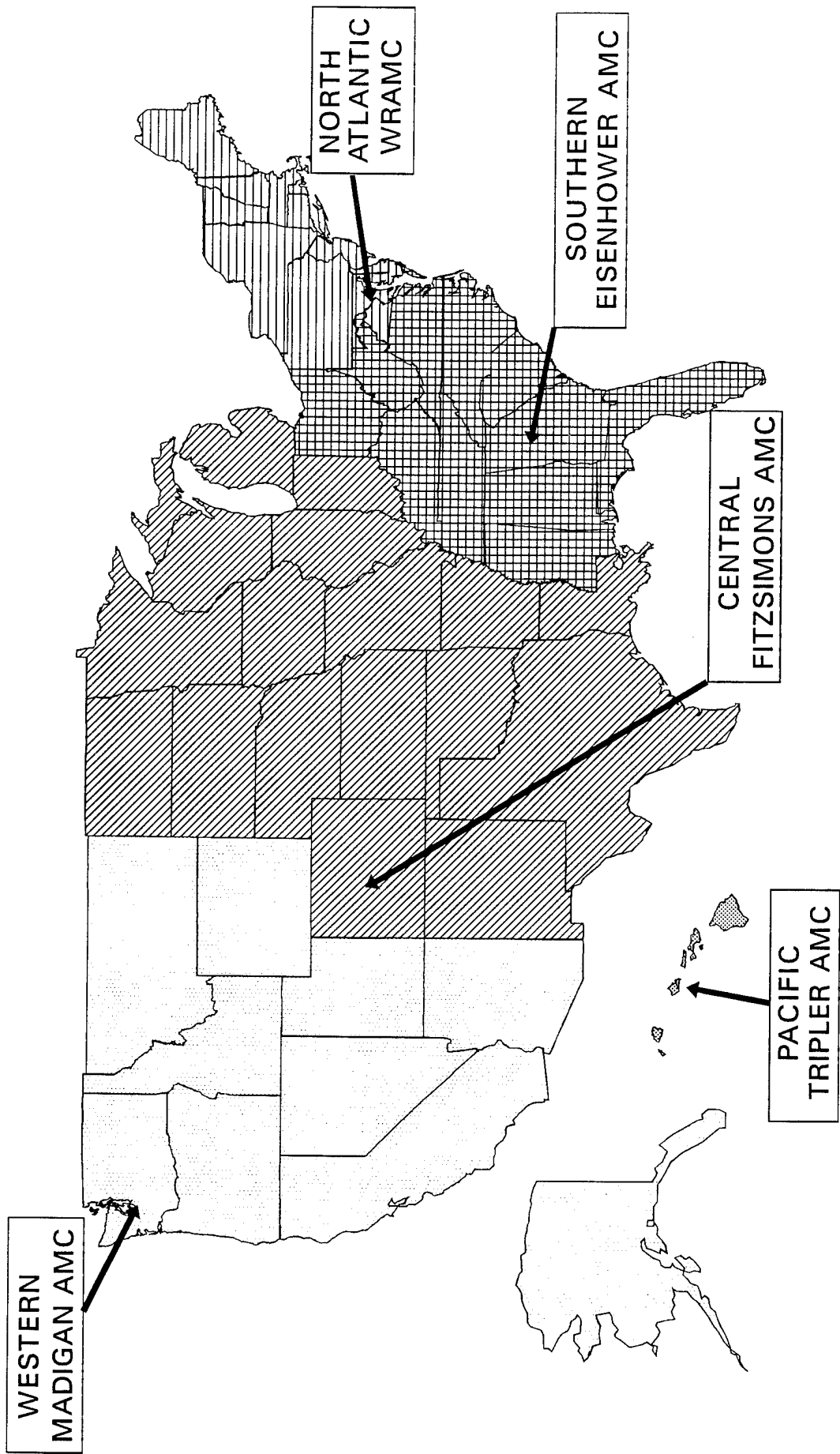
TOTAL APPX 28

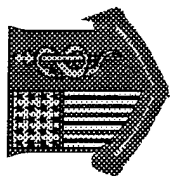
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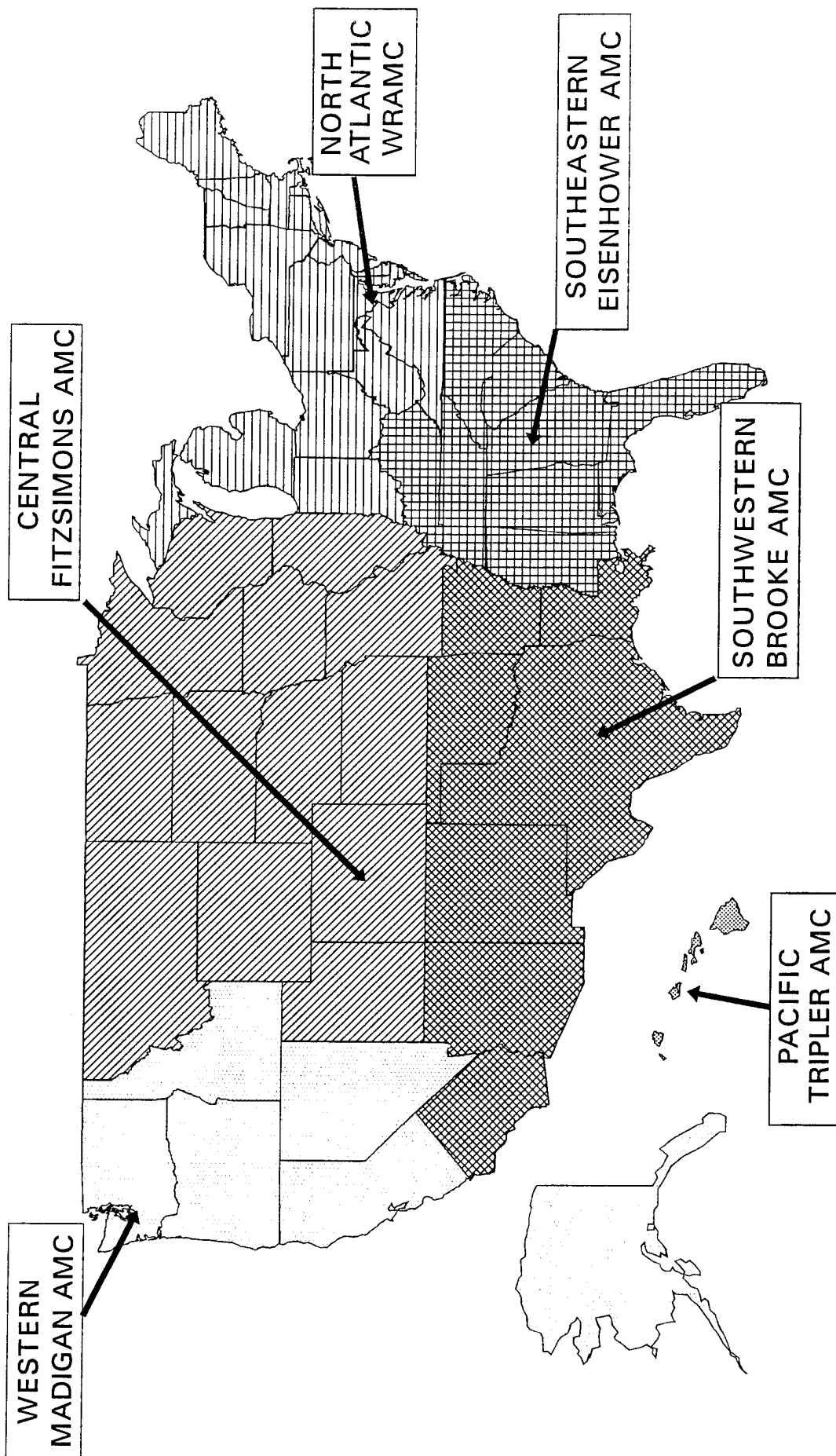
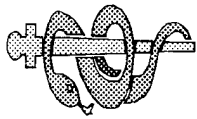


HEALTH SERVICE SUPPORT AREA CONCEPT TASK FORCE AESCULAPIUS



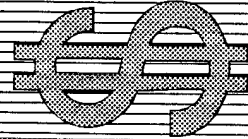


HEALTH SERVICE SUPPORT AREA CONCEPT TASK FORCE AESCULAPIUS

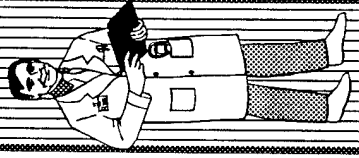


MEDICAL READINESS

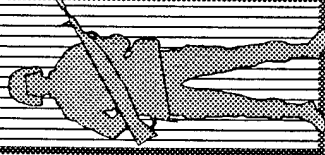
COST
EFFECTIVE
DELIVERY
SYSTEM



PATIENT
CARE



TRAINED,
READY,
DEPLOYABLE
FORCE



HSSA MISSION

TASK FORCE AESCULAPIUS



AMEDD HSSA READINESS ACTIONS

- OPTIMIZE DAILY UTILIZATION OF TOE-TDA MEDICAL ASSETS, ACTIVE AND RESERVE
- INTEGRATE AC-RC TRAINING AND MOBILIZATION REQUIREMENTS
- BUDGET AND DEFEND MEDICAL READINESS COSTS
- ALLOCATE MEDICAL READINESS FUNDS
- PRE-PLAN MTF BACKFILL DURING DEPLOYMENT
 - EXPAND NETWORK COVERAGE
 - SHIFT HSSA ASSETS
 - COORDINATE RC COVERAGE

TASK FORCE AESCULAPIUS



AMEDD HSSA READINESS ACTIONS

(CONTINUED)

- INSURE ARMY MEDICAL READINESS REQUIREMENTS INTEGRATED INTO DOD HEALTH CARE REGIONS
- PRACTICE MTF MOBILIZATION - BACKFILL - DEPLOYMENT ACTIONS
- ESTABLISH PREPARATION PROGRAMS FOR WORLDWIDE CONTINGENCY OPERATIONS
- SPONSOR READINESS-BASED CLINICAL RESEARCH
- FREE COMMUNITY HOSPITAL COMMANDER TO CONCENTRATE ON LOCAL ACCESS - QUALITY - COST ISSUES

TASK FORCE AESCULAPIUS



AMEDD

COMMAND & CONTROL STRUCTURE

AUTHORIZATIONS

1993 1997

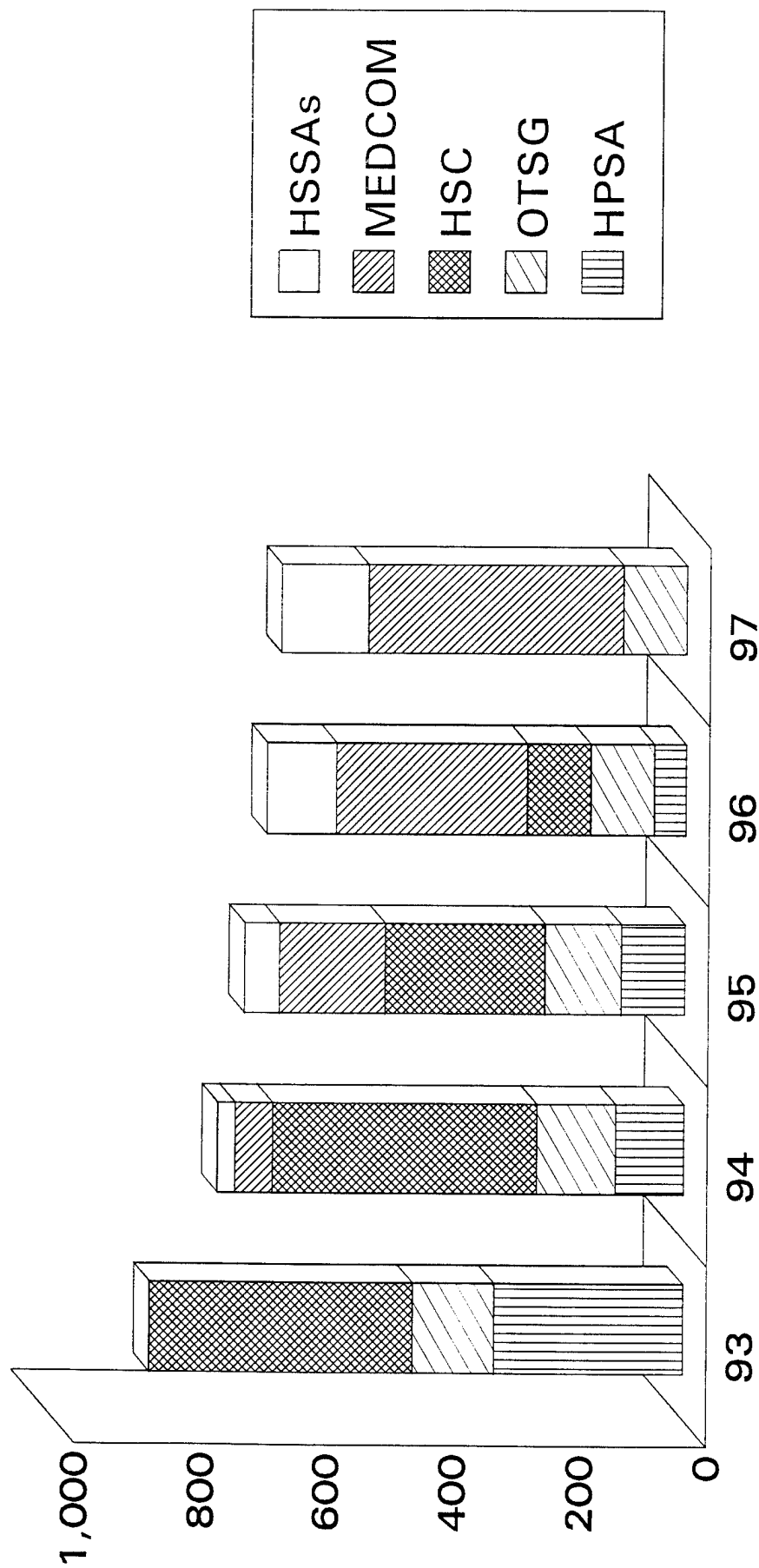
OTSG	128	425	100
HPSA	297		
HSC		384	0
DENCOM		12	12
VETCOM		24	24
MEDCOM		0	402
HSSAs (REGIONS)		0	140

TOTAL 845 678

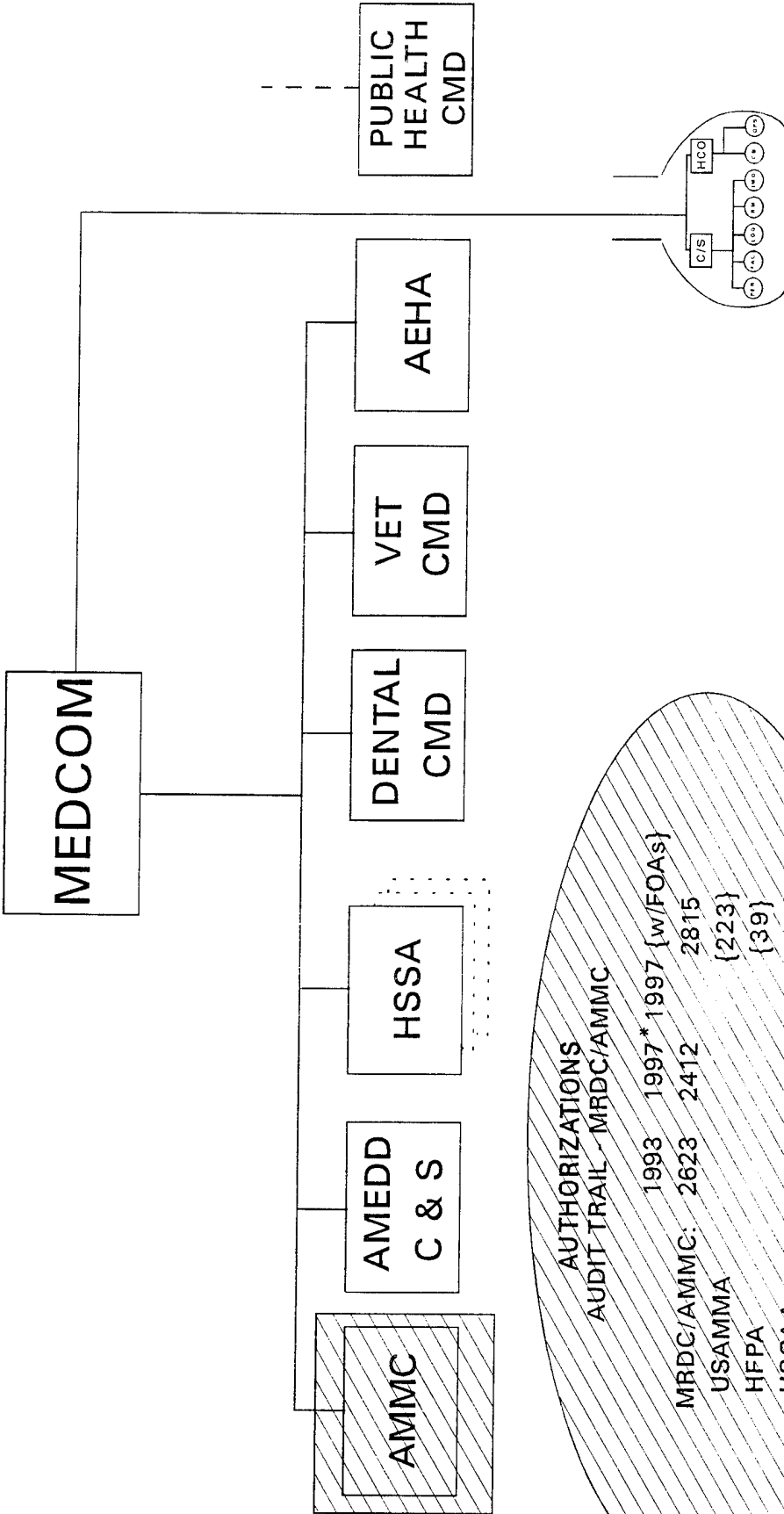
% CHANGE = -19.8%

TASK FORCE AESCULAPIUS 

COMMAND & CONTROL TRANSITION



MEDCOM



AUDIT TRAIL - MRDC/AMMC

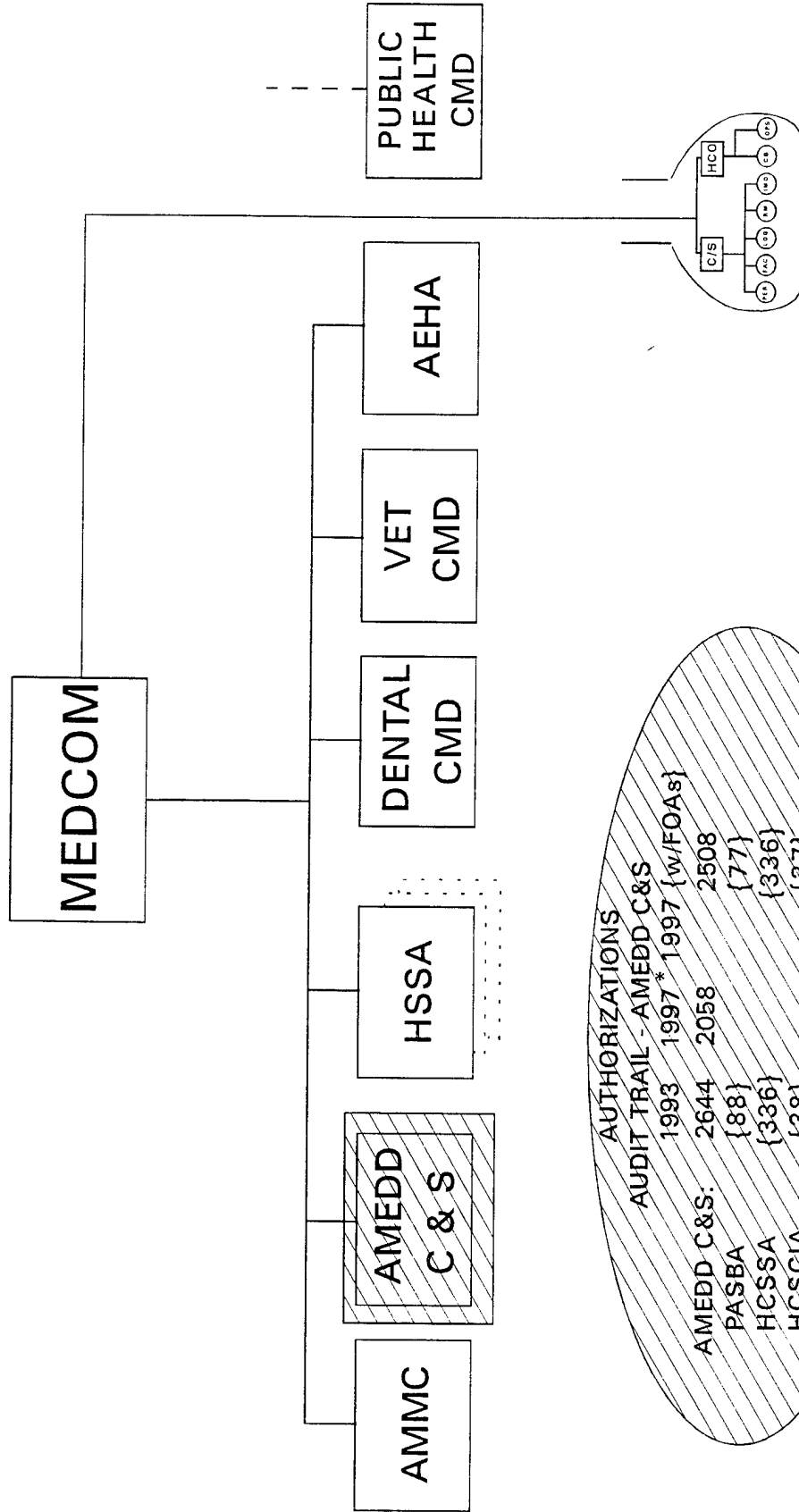
MRDC/AMMC:	1993	1997 *	1997 {w/FOAs}
USAMMA	2623	2412	2815
HFPA			{223}
HSCAA			{39}
			{141}

* Reflects HQDA Programmed Downsizing

TASK FORCE AESCULAPIUS



MEDCOM

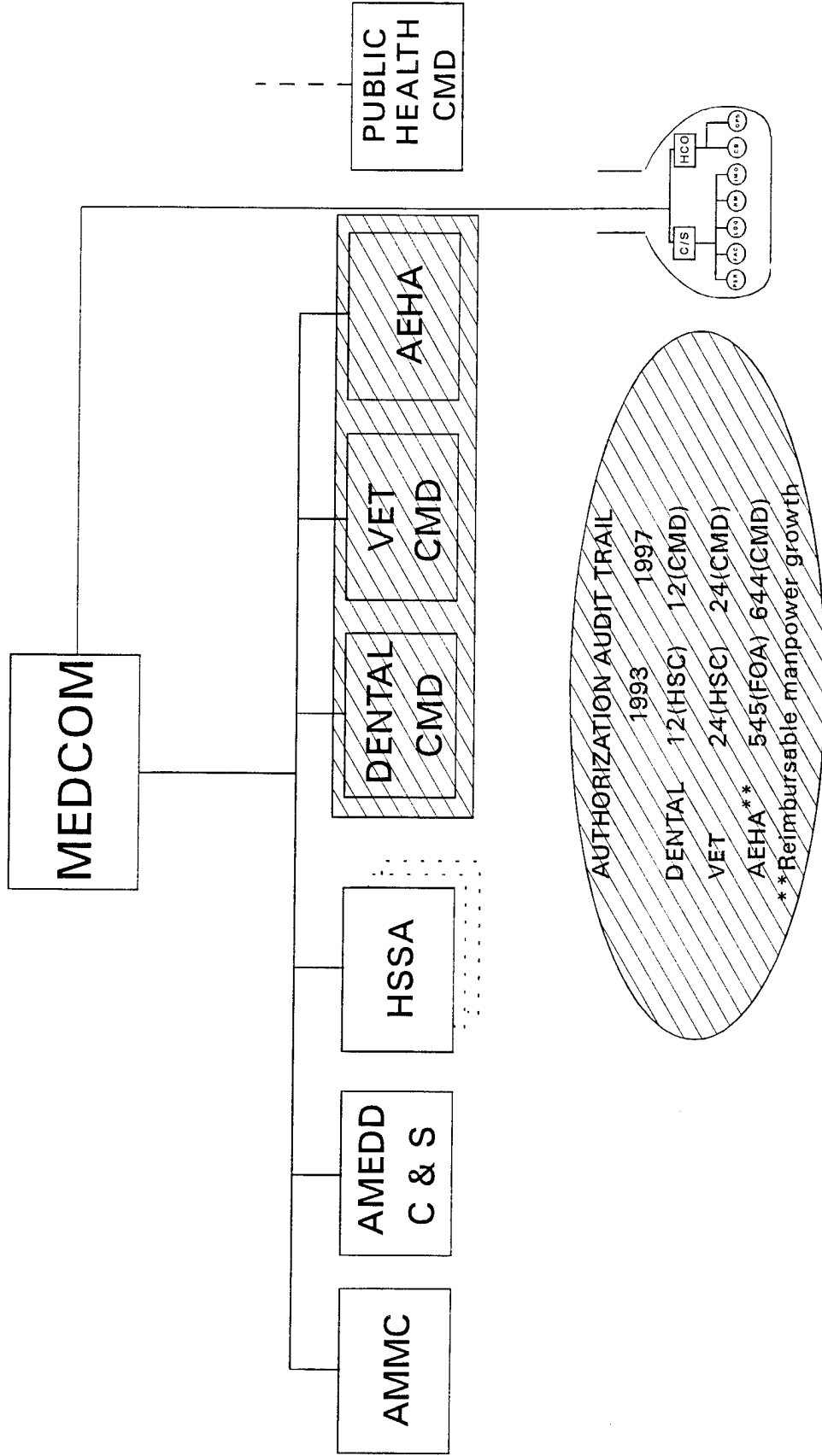


AUTHORIZATIONS

AUDIT TRAIL - AMEDD C&S			
1993	1997	* 1997	{w/FOAs}
2644	2058	2508	
PASBA	{88}	{77}	
HCSSA	{336}	{336}	
HCSCIA	{38}	{37}	

* Reflects HQDA Programmed Downsizing

MEDCOM



CHANGE IN AMEDD FOAS

	AUTHORIZATIONS 1993	1997	NOTES
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OTSG:

HPSA	297	0	
MRDA	2684	0	AMMC
HFPA	39	0	
USAMMA	223	0	

HSC:

AEHA	545	0	PUBLIC HEALTH COMMAND
HCSCIA	37	0	
HCSSA	341	(336)	TO AC&S PENDING
HSCAA	141	0	IMO STUDY
PASBA	92	0	
DHCMMMS	78	0	

TASK FORCE AESCULAPIUS



CHANGE IN AMEDD FOAS

AUTHORIZATIONS	NOTES
1993	1997

JOINT FOAs:

		PROGRAMMED CHANGE
AFIP	363	358
DMSB	17	17
AFPMB	13	13
ASBPO	4	4
JAAFML	3	3
AFEB	2	2

TASK FORCE AESCULAPIUS



IMPLEMENTING CONSIDERATIONS

- ARSTAF CULTURE CHANGE
- RETURN TO THE PENTAGON
- 733 STUDY & BOTTOM-UP REVIEW
- HEALTH CARE REFORM
- WORLDWIDE SCOPE - OCONUS INTEGRATION
- INTEGRATION OF AMEDD TOE/TDA/RC ASSETS

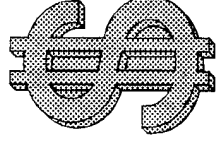
TASK FORCE AESCULAPIUS



AMEDD DRAWDOWN IMPACT

- ARMY -33%
- BENEFICIARIES -16%
- WORKLOAD -14%
- AMEDD MIL -22%
- AMEDD CIV +8%

NO
SHELL
GAMES



TASK FORCE AESCULAPIUS

RESULT OF AMEDD RESTRUCTURING

- STREAMLINED COMMAND & CONTROL STRUCTURE
- CLEAR LINES OF AUTHORITY
- CORRECT MISSIONS (WORK) DONE AT PROPER LEVELS
- READY FOR THE FUTURE:
- • PROTECT AND SUPPORT MTF COMMANDERS AND THEIR ARMY FAMILIES
- • IMPROVE MEDICAL READINESS THRU STRONG TOE-TDA-RC INTEGRATION
- • EFFECTIVE RESPONSE TO DOD(HA) AND NATIONAL HEALTH CARE REFORM INITIATIVES

TASK FORCE AESCULAPIUS 

SUMMARY

- SENIOR AMEDD OFFICER IN COMMAND
- REDUCED NCR PRESENCE 76.5%
- ELIMINATED FOAs
- REDUCED HQ AUTHORIZATIONS 19.8%
- UNCOVERED ALL ASSETS
- ORGANIZED FOR FUTURE

TASK FORCE AESCULAPIUS



ENCLOSURE 9



DASG-TT

REPLY TO
ATTENTION OF

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
5109 LEESBURG PIKE
FALLS CHURCH, VA 22041-3258



- 2 DEC 1993

MEMORANDUM FOR AMEDD Stakeholders

SUBJECT: Charter for Task Force Aesculapius II (TFA II)

I. MISSION: Assist The Surgeon General in developing a world class combat casualty care system, with the necessary sustaining base, by promoting and actively monitoring the implementation of the newly designed Medical Command including transition of the Office of The Surgeon General, Health Services Command, and Major Subordinate Commands (MSCs).

II. AUTHORIZATION, RESPONSIBILITY, ACCOUNTABILITY AND AUTHORITY:

A. AUTHORIZATION: The MEDCOM Commander/The Surgeon General of the Army

B. RESPONSIBILITY:

1. Assist TSG/MEDCOM Commander in completing the AMEDD reorganization.
2. Develop a detailed master plan from the general Task Outline (Encl) and oversee implementation for the MEDCOM, including all MSCs.
3. Proactively engage all key elements of the AMEDD in the process of transition to conform to the structure of the requisite organization.

C. ACCOUNTABILITY:

1. Validate mission and functions for the OTSG, MEDCOM, and all MSCs.
2. Identify the key outputs of the MSCs in the reorganized MEDCOM.
3. Analyze and advise on the critical systems, processes, and functions that sustain the new organization.
4. Integrate critical technological advancements into the transition.
5. Promote a change of culture that supports the values, goals, and objectives of the new MEDCOM.
6. Monitor and document progress of a detailed plan of the hand-off and roll-over of organizational functions and development of revised systems.

D. AUTHORITY: In carrying out the above responsibilities, TFA II has tasking authority thru AMEDD Commanders. Major General Commanders retain coordinating authority to delay actions pending TSG review.

III. ADMINISTRATIVE SUPPORT: OTSG and MEDCOM staff.

IV. SUPERVISORY AND COMMUNICATION CHANNELS:

A. TFA II is accountable to the MEDCOM Commander/TSG.

B. Direct communication is authorized with internal/external stakeholders.

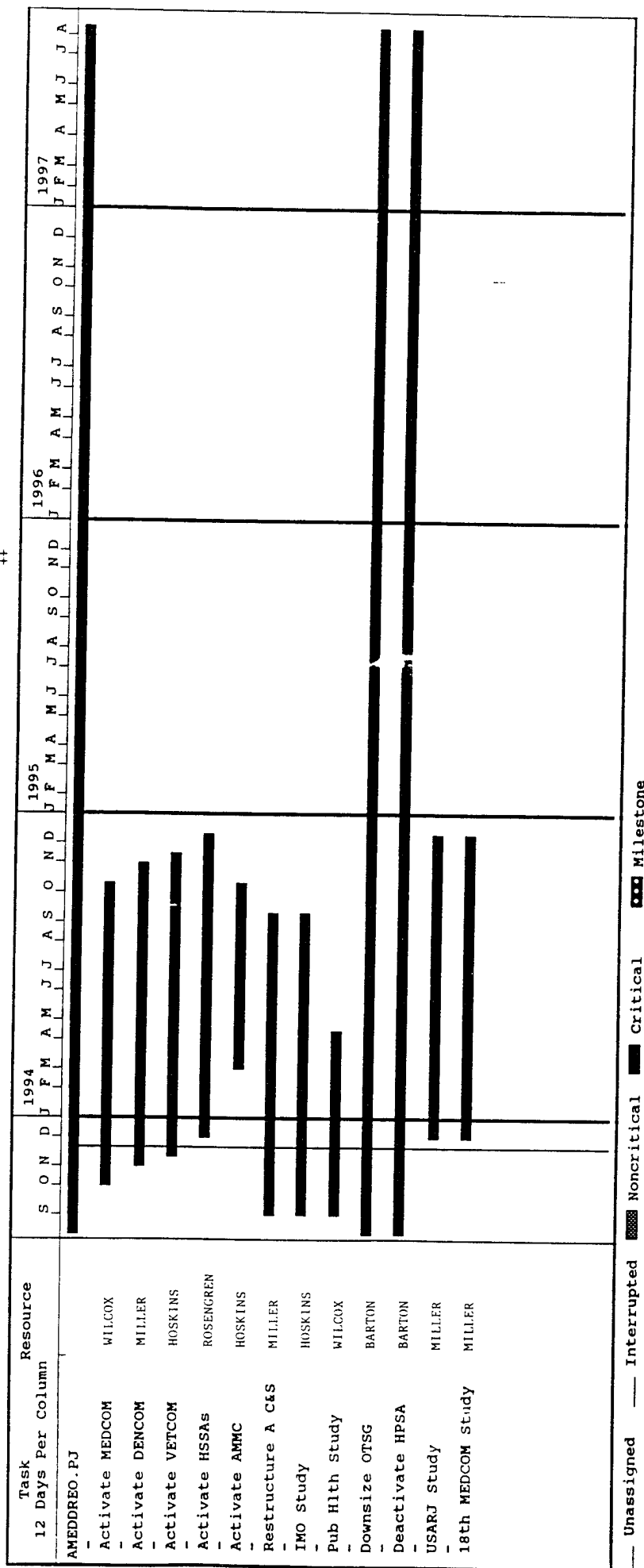
V. APPOINTMENT: The following personnel are appointed to TFA II: BG Russ Zajtchuk, MC; COL Douglas Barton, MS; COL Osvaldo Bustos, MC; COL Mary Messerschmidt, AN; COL John Miller, DC; COL John Wilcox, MS; LTC Clyde Hoskins, VC; MAJ James Rosengren, MS; CPT Peter Shaul, MS.

VI. TERMINATION AND REVIEW: TFA II terminates with the activation of the Medical Command and hand-off of its functions to the Strategic Business Office.

Encl

John M. Lanoue
ALCIDE M. LANOUE
LIEUTENANT GENERAL
The Surgeon General

++



Unassigned — Interrupted [Pattern] Noncritical [Pattern] Critical [Pattern] Milestone [Pattern]

TASK FORCE AESCULAPIUS

PHASE II MEMBERS *

- BG RUSS ZAJTCHUK, MC
- COL/BG STEPHEN XENAKIS, MC
- COL MARY MESSERSCHMIDT, AN
- COL JOHN MILLER, DC
- COL JOHN WILCOX, MS
- COL DOUGLAS BARTON, MS
- LTC CLYDE HOSKINS, VC
- MAJ JAMES ROSENGREN, MS
- MAJ HOWARD SCHLOSS, AN
- MAJ PETER SHAUL, MS

* TERMS OF SERVICE VARIED FOR INDIVIDUAL MEMBERS



TASK FORCE AESCULAPIUS

ENCLOSURE 10

U. S. ARMY
HEALTH CARE SYSTEMS SUPPORT ACTIVITY
(HCSSA)

OVERVIEW

I. Background:

Health Care Systems Support Activity (HCSSA) is a 250 (approximate) person organization composed primarily of information technologists and associated management and support staff. The activity refers to itself as the U.S. Army Medical Command "Center of Excellence for Information Technology". It began operations as a separate organization in October, 1977. Prior to that, it was combined with the Patient Administration and Biostatistics Activity (PASBA) to constitute the U.S. Army Health Information Systems and Biostatistical Agency. HCSSA currently constitutes one of the few broad based nuclei of information technology (IT) expertise that can truly be considered an AMEDD - wide corporate asset. As such, it is a key and essential element in helping the AMEDD win the information war.

The primary missions of HCSSA are:

- to produce, implement and maintain automated medical systems for the Army worldwide
- to produce, implement and maintain data, voice and satellite communications for the MEDCOM
- local area network design, installation and support
- video teleconferencing
- training and consultancy

HCSSA is comprised of many highly talented experts in several of the various IT disciplines such as application programming, computer systems, communications systems, data base management, tactical information systems, and others. A small number of functional customers of IT are also assigned to the organization. These include nurses, a dentist, medical technicians and resource managers. Direct expenditures of the activity are approximately \$12 M annually which is used to support a wide variety of medically related automated information systems worldwide. A small sampling of the systems support include: Dental Workload Reporting System, Hospital Formulary System, Spectacle Request Transmission System, MEDSTOC, AMEDD Property Accountability System, Health Risk Appraisal System, MEPRS and Theater Army Medical Materiel Information System. The activity is also heavily involved in implementation of LANs and, eventually a wide-area network throughout the MEDCOM.

In July 1993, HCSSA was downsized in accordance with AMEDD wide personnel reduction goals. As a direct result of these staffing cuts, HCSSA initiated an organizational "reinvention" project. The model chosen for their project was that of self-directed teams. The activity is presently in the final stages of physical relocation in its reorganization process and will not have an initial assessment of the effectiveness of the new structure for several months.

One of the principle items providing impetus for the reorganization was a perceived lack of customer focus. This may have been at least partially due to perceptions of no organized decision making processes focused on prioritizing projects supported by the activity. With a breakdown in coordinated business process planning, an atmosphere conducive to perpetuating "pet" projects, while ignoring new or higher

priority work may have developed. Improving internal business planning processes was an essential goal of the reinvention project.

It must be noted, however, that from a theoretical organizational design perspective, self-directed teams tend to facilitate continued uncoordinated corporate planning. This is reflected in the absence of the basic properties of accountability and authority which, when combined, serve to define the nature of working relationships. Knowing precisely what work a person is being held accountable for and defining the authority associated with each accountability establishes the basic foundation for working interactions. Lack of clarity regarding the accountabilities and authorities assigned to a given role is a major source of conflict between people as they try to work together. Self-directed teams are frequently touted as being motivational for individual employees, but they can easily blur lines of authority. How HCSSA manages this seeming incongruity will be interesting to follow in future assessments.

II. Theme: HCSSA has recently reorganized itself around self-directed work teams to continue to provide high quality, value added service to its existing customer base.

III. Findings:

- HCSSA lost 37 upper and middle level management personnel in a recent downsizing initiative.
- HCSSA reorganized into self-directed teams in order to cope with these personnel losses.

- HCSSA provides a wide variety of information related services to the MEDCOM:
- There is a widespread perception among MEDCOM personnel that HCSSA consists of technically oriented staff who have little appreciation for meeting customer- based information requirements.
- No strategic information plan exists within the MEDCOM.
- Funding for most HCSSA projects is obtained directly from MEDCOM headquarters and not from the customer base.
- The internal reorganization has had a minimal impact on some teams - they continue to work on the same projects.
- There is confusion among AMEDD personnel as to what types of information services they need - many complain about existing products/services e.g. CHCS, but these same individuals provide little or no definition of requirements.
- Some HCSSA personnel report that the self-directed teams lack focus and are not functioning effectively.
- HCSSA has no apparent understanding of the costs associated with providing a given service and thus what price to charge a given customer.
- Most AMEDD personnel feel that the information field is in disarray and that little or no value-added support is being provided.

IV. Issues:

1. What is the best way to organize HCSSA to meet customer needs?
2. Is the service provide by HCSSA value-added and cost effective?
3. What is the most effective way for the MEDCOM to procure and deliver information related services: design and staff an organic information service activity, contract externally for such services, or rely on a combination of the above two strategies?

V. Discussion:

The information functional area receives more interest and generates more adverse reaction than any other functional area within the AMEDD. There is an almost universal perception that the entire information field is "broken". Yet, most personnel within the AMEDD recognize that "winning the information war" is a central challenge as the Army implements Force XXI doctrinal changes. This widespread frustration among AMEDD personnel has been specifically directed at HCSSA and other AMEDD information activities. In the original analysis and design of the MEDCOM, it was decided not to conduct an in-depth analysis of the information functional area because the Deputy Chief of Staff for Information (DCSIM) had recently initiated a major study of the field by an outside contractor. It was recognized, at the time, that this would be a multiyear study.

However, since information applications were so central to the AMEDD reorganization, it was also decided to embark on a short term study of customer needs and perceptions. The short-term study was completed in the summer of 1994. The results of the short term study were predictable. Most customers were unhappy with the nature and quality of support being provided by the information community. Many customers felt that existing information personnel were totally uninformed about the type of information required to run a health care organization. Customers believed that existing support/service staff were so technically focused that they were unable to effectively communicate with the customer base. At the same time, Health Affairs was heavily involved in implementing a common information system (CHCS) throughout the entire DoD health care system. Many customers believed this system (CHCS) to be unwieldy, outdated and too expensive.

While the short term study reflected much criticism regarding the information field, it was also obvious that the customer base shared partial responsibility for the negative outcomes. For example, customers, while quick to criticize existing systems and support levels, neither understood their needs nor clearly articulated them to the information specialists. In many cases, health care staff did not even know what type of information was currently available to them (e.g. MEPRS data). Thus, responsibility for the perception that the AMEDD information functional area is in disarray should be shared by both customers and functional experts alike.

Results of the long term study were recently made available. Generally, these results reinforced the earlier conclusion that information personnel need to improve their overall customer focus. It was suggested that a number of account representatives be appointed to improve the quality of communication between the customer base and

information support staff. No other dramatic or far-reaching recommendations appeared in the long term study report.

Much day-to-day information related support is provided by HCSSA. As reportedly previously, HCSSA recently reorganized around self-directed teams in order to better provide such support. With its reinvention initiative, HCSSA has taken a bold step in trying to fix itself and become more responsive to the IT needs of the MEDCOM. During interviews of the activity's employees, there were many positive comments. Predictably, there were also negative comments. Due to the timing of the reorganization project and this organizational design review, there is no reliable way to ascertain the effectiveness of the new organization at the present time. Proof of success or failure will develop over the next few months as customer reaction accumulates.

Existing perceptions of the quality of support provided by HCSSA are essentially negative. Many AMEDD personnel believe that the support is too technical, does not meet customer needs, and that it is too difficult to communicate with existing staff personnel.

The overall finding of the TFA task force also concluded that HCSSA was not customer focused and that the quality and value-added nature of its services continued to be questioned. Further, the reorganization into self-directed teams was not improving the overall effectiveness of that service. For example, prioritization of project work and the effectiveness of the business planning process continued to be a problem.

While some of the breakdown in business planning can be attributed to internal HCSSA factors and practices, it is also indicative of a systemic, AMEDD-wide information resource management (IRM) problem. The systemic problem is beyond the scope of HCSSA. It is mentioned here because of the issue of the CIO, the MEDCOM DCSIM and AMEDD-wide "corporate assets", such as HCSSA, PASBA, portions of the Center for Health Education Studies, and the Ft. Detrick Directorate of Information Management are inextricably entwined much like King Gordius' knot.

Given the nature of the above discussion, a central issue facing the AMEDD is how best to meet internal information service and support needs. Should HCSSA be given an opportunity to fix the problems associated with its reorganization or should the MEDCOM consider contracting out for all necessary information services? A third option also exists and that is to employ a combination of both of the above described options provide some internal support while simultaneously increasing the amount of outside contractual support. This latter option would lead to further downsizing of HCSSA.

No one questions that some of the support currently being provided by HCSSA is of value, hence contracting the entire activity out does not seem to make good business sense. However, the only true way to determine whether or not a service is cost effective is to require customers to pay for that service. As long as a service activity is provided its own operating budget customers tend to ignore the costs associated with the provisioning of such services. Thus, most (or all) of HCSSA's budget should be provided by the customer base. If customers are unwilling to pay for a given level of services then that service should be eliminated. Therefore, it is recommended that the MEDCOM change the flow of money to HCSSA - the money

should go to the major subordinate commands who in turn provide funding for information related services, as required.

Initially, the CIO position was created to fix the myriad of problems associated with the information functional area. Many problems continue, although in fairness the CIO position has been in existence less than two years. Nonetheless, if "winning the information war" is a prime objective of the MEDCOM, it should seriously revisit the issue of how best to organize to meet that objective. The current strategy reflects a series of disparate organizational elements focused on meeting a variety of customer needs. No overall corporate information strategy exists.

Some existing information focused activities have been operating for years with minimal analysis as to their overall cost effectiveness (e.g. PASBA, HCSSA etc.). The CIO position was created to integrate the diverse information activity and to provide a clear blueprint for the future. To date this has not occurred. Perhaps one reason why more progress has not occurred, is that the work of integration and planning is sufficiently complex that it warrants general officer leadership. If the AMEDD is really serious about "winning the information war," a separate general officer led task force should be established. Such a task force should be dominated by non-information oriented staff and challenged with developing a long-range health care focused information plan. All existing information activities should be integrated into this task force and the task force should determine how many, if any, existing services should be contracted.

VI. Recommendations:

1. Establish a general officer led task force to develop a long-range health care focused information plan and to integrate existing diverse information support activities into a comprehensive value added, cost effective organization.
2. The MEDCOM should change the flow of funding for all service related activities. Customers should be required to pay for such services. Such a change should be phased in over a five year period e.g. 20% transfer per year.
3. Required internal fixes to the HCSSA organization should be implemented immediately.
4. The MEDCOM should consider reducing the aggregate size of the existing information support activities.

U.S. Army Health Care Systems Support Activity Staff

I. BACKGROUND:

Historically, the U.S. Army Health Care Systems Support Activity (HCSSA) was organized in the traditional way with a Commander, Deputy Commander, Division/Office and Branch Chief structure. In July 1993, the Activity was downsized in accordance with AMEDD-wide personnel reduction goals. Thirty-seven upper and middle level staff elected to take early retirement as part of this downsizing effort. These spaces were abolished and subsequent recruiting actions were prohibited by law from filling these positions. The loss of this many managers severely strained the organization and necessitated a new way of doing business. The Command group elected to rebuild the Activity around self-directed work teams.

II. THEME: Organizing around self-directed teams was intended to produce more productivity, a better customer focus, and an increase in overall effectiveness.

III. FINDINGS:

A. HCSSA is made up of three different types of self-directed work teams; home teams, temporary project teams, and a special corporate project team (TAMMIS). These teams are either project-related, functional, or customer focused teams. Home teams are permanent and project teams exist for the duration of a given project. Each member of a project team also belongs to a home team which they return to upon completion of a given project.

B. The self-directed work teams were constructed by the Transition Team (e.g. the remnants of the former command group). Individual team members were selected from various skill sets and multiple grade structures. Existing HCSSA personnel were given the opportunity to complete a skills survey assessment in which they were able to identify three areas where they would like to be assigned, in order of preference, and according to their skills.

C. Requests for projects flow into the Activity thru the Business and Executive Support Team. The request is then forwarded to the Business Analyst Team (BAT) 1 or 2 where a Business Analyst (BA) is assigned. The BA performs a business analysis, finds out exactly what the customer wants, and forms a project team. To date, project teams have been formed by requesting volunteers. Volunteers are further narrowed down by the team Business Coordinators (BC)s as to their availability to take on new project work and the specific skills required therein.

D. Only a couple of new project teams have been formed under the new self-directed team structure. Most of the project teams have been working together for years. Each project team has an elected team leader which is separate from the home team BCs.

E. The MEDCOM Admin Support Team is made up of individuals transferred from the DCSIM to HCSSA's TDA. There are currently three 334 series (Computer Specialists) who have also been transferred to the HCSSA TDA who have not yet been placed in the new team environment. They are currently still assigned to their DCS' at the MEDCOM. A GS-04 clerk, who also belongs to HCSSA, is assigned to DCSPER to type award certificates for the MEDCOM.

F. Home teams elect a BC to represent the team when circumstances so require. The BC is responsible for the day-to-day administrative functions of the team, i.e., STARCIPS (timekeeping), DD 1556 (Request for Training), DD 1610 (Request for TDY), and SF 71 (Request for Leave). They also function as the pipeline for the flow of information from the Work Force Improvement (WFIT) and BC Working Group Teams to their respective team members. It has been reported by some of the technical personnel serving as team BCs that they are spending too much time on administrative duties pertaining to their team.

G. Teams are without a coach and it is the feeling of some team members that there is no clear direction and no accountability for the completion of tasks. There is no clear understanding of who sets the priorities for the team.

H. Some individual team members perceive inequitable output among the members. There is no accountability for output nor is there an expectation of team output.

I. A supervisory level has been re-established in the Activity. It was reported by some interviewees that there appeared to be a sense of chaos and confusion among HCSSA personnel. Although disputes and personnel problems (low performing individuals) are supposed to be resolved at the team level, teams do have the option of bringing their concerns to the WFIT or to the not yet established Executive Steering Council (ESC).

J. The ESC will be the final supervisory body formed. The ESC will be responsible for the strategic planning of the Activity. The HCSSA Commander will name the ESC at a later date. Once the ESC is named the WFIT will no longer exist.

IV. ISSUES:

- A. Have self-directed teams been properly formed?
- B. Should there be a manager assigned at the team level to establish priorities and clarify accountabilities?

V. DISCUSSION:

Most of the personnel interviewed in this study reported that they approve of the new self-directed team structure. In their opinion, HCSSA needed to change the way work is carried out. Many, however, do not necessarily agree with the way this change has been implemented. Some feel that the process was not done fast enough, while others do not agree with the make-up of teams. All personnel, however, are willing to give the change process a chance. All agree that HCSSA's main focus should be

on finding a better way to do business and for gaining a better customer focus.

Some individuals perceive inequitable output among team members. There is no expectation nor is there any accountability for team output. The current structure does not readily allow for the clear assignment of accountability for the completion of assigned tasks.

Almost all team BCs reported that they spend too much time on administrative functions rather than the technical/functional aspects of their jobs.

HCSSA is in the process of fundamentally changing its internal work culture. Such change takes both time and patience. HCSSA personnel are used to projects coming into the Activity directly to the appropriate area of expertise. The Division/Office/Branch Chief then assigned work to be accomplished. The establishment of work priorities, budget requirements, disciplinary actions, etc. are now to be handled by a group of individuals known as a team. Most are not comfortable with this new process.

VI. RECOMMENDATION:

- A. A clear understanding of accountability and authority needs to be established at the team level.
- B. The management hierarchy within HCSSA needs to develop and implement management processes that can effectively control the flow of work within HCSSA.

C. Teams need to understand and accept that they are accountable for producing a given output.